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### The changing experience of work of consultants in NHS Scotland

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# THE CHANGING EXPERIENCE OF WORK OF CONSULTANTS IN NHS SCOTLAND

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# CONTENTS

ACKNOWLEDGEMENTS	3
EXECUTIVE SUMMARY	4
BACKGROUND TO THE STUDY, RESEARCH QUESTIONS AND OBJECTIVES	10
METHODOLOGY	21
FINDINGS	24
DISCUSSION	88
CONCLUSIONS	94
REFERENCES	96
APPENDIX 1: INTERVIEW SCHEDULE FOR INTERVIEWEES	100
APPENDIX 2: SURVEY QUESTIONNAIRE	102
APPENDIX 3: BREAKDOWN OF DEMOGRAPHIC GROUPS	108

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## EXECUTIVE SUMMARY

### Background and Rationale for the Study

1. The Scottish consultants committee (SCC) of the British Medical Association sought to understand the nature of the changing experience of work among consultants in NHS Scotland following anecdotal reports from members concerning a loss of autonomy and authority over recent years. The SCC also sought to comprehend the range of views held by consultants on their changing experience of work, their nature, antecedents and consequences, and the extent to which views varied among consultants employed in the NHS in Scotland.

2. To address this question we conducted an extensive literature review into explanations of loss of autonomy and control among professions in healthcare, and on doctors' changing experience of work. This review led us to develop a framework that linked explanations of potential loss of autonomy and control among consultants – so-called deprofessionalization - to key outcomes: (a) their trust in managers and Boards, (b) the nature of their engagement with their immediate work, their clinical teams, their employers and the NHS in Scotland, (c) their ability to express their ideas and feelings, and participate in decision-making – otherwise known as 'voice', and (d) their perceptions and accounts of the effectiveness of the healthcare system in Scotland.

### Methods

3. We undertook a mixed-methods approach to data collection. The first stage involved in-depth, semi-structured interviews with 68 consultants in Scotland during the period May to September 2014. The questions were informed by our literature review but we were also open to directions that interviewees wished to take us in since our objective was help them reflect on, and articulate, their experiences since first appointment as a consultant.

4. Interviewees were selected to ensure maximum variation among consultants in all boards in Scotland, and in all types of hospitals, specialties, contract and age ranges. The number of interviews conducted was also guided by 'theoretical saturation', which applies when interviewers feel they are learning less and less from additional interviews.

5. Initially, interviewees were selected from a BMA database of consultants in different boards in Scotland. This group accounted for slightly more than half of the final sample. These interviewees helped enlist colleagues in their boards who were willing to be interviewed, especially is specialties and career stages that were underrepresented in the initial sample. Finally, to mitigate sampling bias as best as we could, we sought interviewees who were neither initial volunteers nor volunteers secured through BMA contacts to assess whether their views were different from earlier interviewees.

6. Interviews were transcribed verbatim, which produced more than 1500 pages of text. Using a coding frame, this text was analysed for common themes and variations in views on these themes, which were subsequently used to design a survey for a follow up survey. This survey aimed to understand the extent to which views were held to build on the in-depth and nuanced views provided by the interviews

7. The survey consisted of 53 questions, divided into six sections on themes generated by the literature and from issues raised by the interviews. Some of these sections drew on pre-validated items used to measure trust, voice, and different types of engagement; others were designed by us to assess issues raised by the interviews such as perceptions of clinical and medical management, rationales underlying decision-making, etc. These were followed by six questions on the demographic profile of the respondents. The survey was piloted on a group of consultants, who provided extremely useful feedback that led to a revision of some of the language and categorization of consultants used in the survey.

8. The revised survey was distributed online to 3740 consultants using the BMA's database, via an email invitation from the BMA and the research team. Potential respondents were invited to use a web link to access the survey. A reasonably good response rate for online surveys of 28.6% was achieved, with 1058 consultants completing the questionnaire.

9. An 'any further comments' section was provided in the survey, which produced 430, frequently lengthy and reflective, free text responses. These data were also subject to analysis and have contributed substantially to the overall picture from our mixed method data collection.

## **Key results**

10. The interview and survey data suggested that consultants perceived significant change in the dominant rationales governing decision-making in their work situations and in the NHS generally. A business-related rationale was seen to dominate decision-making rather than the rationale of medical professionalism, which consultants tended to equate with good patient care. While the NHS has always had to accommodate potentially conflicting rationales, consultants felt that the balance had 'tipped too far' towards business and financial decisions dominating how work was organized and evaluated, and that such a trend was inconsistent with effective and efficient patient care. During the interviews it was also evident that many consultants linked the business and finance rationale to a political rationale. This political rationale was seen to arise from (a) politicians' promises to the general public to meet increasing demands from an aging population for a better quality of healthcare without being able to fully resource such promises, or (b) from direct political interventions in how and where healthcare funds were spent. However, it was also evident that those consultants who had previous or current experience of medical management were more accepting of the conflicting nature of healthcare rationales and the needs to balance them in decision-making.

11. This clash between business-related and political rationales on the one hand and medical professionalism on the other, appeared to be the underlying cause of relatively widespread feelings and expressions of deprofessionalization among our interviewees and survey respondents. Deprofessionalization was expressed in the following ways:

- i) Consultants saw increased patient demands as challenging and in some cases misplaced. They attributed such views to a political rationale, to the role of the media in promoting 'bad news' stories about the NHS, and to enhanced access to self-diagnosis through the Internet in creating a 'want it now' culture. Patient demands and expectations, however, were unequally distributed among the Scottish population. In under-privileged sections of Scottish society, many patients and their families were still more unlikely to challenge medical opinion or practice, which was not the case with the affluent middle-class, who often placed greater demands on consultants. Nevertheless such challenges did not cause consultants to feel that their status with patients had been diminished; indeed interview accounts and the survey data suggested that consultants felt they still enjoyed high levels of respect and trust in their judgement, and perceptions of integrity, despite the constant, as they saw it, media attention on failings in the healthcare system. Moreover, many consultants welcomed more informed patients and challenge to the previous image of doctors as omnipotent and distant.
- ii) The levels of negative comment and graphic accounts of how increasing bureaucracy and non-clinical 'managerialism'<sup>5</sup> had shaped changes in their work experience were among the most marked points in our findings. These feelings were especially strong in relation to the dysfunctional consequences associated with the reliance on a performance management approach to reform in NHS Scotland, including: (a) waiting times and targets, (b) the variable implementation of the 2004 consultant contract (c) multiple layers of needless paperwork, and (d) the increasing power of non-clinical managers, who were seen to exercise a strong degree of control over the consultants' working lives. Consultants tended to see the increasing power of non-clinical managers as an especially worrying development associated with performance management and inconsistent with improving patient care. Although many consultants had sympathy for non-clinical managers' having to do a difficult job in difficult circumstances, many spoke of the imbalance of power having gone too far in the direction of detached managerialism, and a need to redress this imbalance. However, not all consultants were of this view: younger consultants and, particularly, consultants with experience of medical management tended to express less negative views of increasing bureaucracy and managerialism.
- iii) Increased regulation introduced by elite medical bodies such as the GMC was also seen in negative terms. Attempts to introduce processes such as revalidation and appraisal were viewed as unhelpful initiatives, which neither improved system effectiveness nor aided the development of early and mid-

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<sup>5</sup> A belief in the values and practices of professional management as a solution to organizational problems, which has become a marked feature of the NHS over the past three decades

career consultants. Although appraisal was typically described as good in theory, the practice of 'box-ticking' had caused the system to lack validity among appraisers and appraisees, and to be deemed a 'waste of time and money'. The issue of who was selected to fulfil the role of appraiser was frequently raised, especially in relation to the appraisers who were thought to align with a business or financial rationale.

- iv) The introduction of clinical leadership and medical management drew mixed views. On the one hand, most consultants wished to see more consultants in such roles, but, on the other, the experience of appointing consultants to these positions has not led to a majority of consultants' experiencing major improvements in the system nor to perceptions that medical judgements were being taken into account at Board management level. Indeed, in line with much of the literature on clinical leadership, consultants without experience of medical management tended to see colleagues who had taken up leadership positions as having become incorporated into the bureaucracy and a managerial agenda. However, we found that consultants with experience of medical management and clinical leadership tended to hold a more positive view of medical managers' capabilities to generate change. Nevertheless, medical managers acknowledged that the part-time nature of many clinical management roles limited their impact, and sometimes caused clinical managers high levels of stress resulting from role conflict.
- v) There was limited evidence of the routinization of work. Consultants appeared to find their jobs appropriately challenging, with many reporting increased job challenge during their clinical careers as consultants. However, interview accounts and the survey data stressed that their medical judgements were becoming routinized, with new bureaucratic procedures and the control exercised by non-clinical management limiting their clinical freedom to the detriment of patient care.
- vi) There was some evidence that consultants saw the introduction of unnecessary dress codes, changes to their quality of office accommodation and a lack of meeting spaces as a symbolic challenge to their status, and as inconsistent with effective working and with the traditional 'communities of practice' that had previously characterized consultants' working experience.
- vii) There was also evidence that some consultants felt increasingly devalued because managerial values and practices, and associated bureaucratic control, had challenged their status as the most highly qualified professionals in the healthcare system. Instead, some reflected that they were being seen as members of a healthcare 'workforce', increasingly subject to a wage-work bargain like any other healthcare worker. One consequence of these feelings of possible 'proletarianization'<sup>6</sup> was survey evidence, especially from earlier career consultants, showing a greater willingness to take collective action in pursuit of grievances.

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<sup>6</sup> Perceptions of proletarianization relate to the de-skilling and routinization of professional work and to perceptions of professional status being downgraded.



12. There was strong evidence of a lack of trust in managers in general and trust in senior management. Consultants responded to performance management, bureaucratic control and managerialism by expressing a marked lack of trust in the competence and integrity of non-clinical managers and, to a lesser extent, medical managers. Not surprisingly, consultants with experience of medical management were more inclined to trust the system, and to have a more positive view of doctors becoming involved in clinical leadership and medical management as solutions to improving the system through consultation and communication.

13. However, contrary to what might have been expected in organizations characterized by low trust dynamics, both the interviews and survey data on engagement showed that consultants were highly engaged with their jobs, with their clinical colleagues and with the values of the NHS. Engagement with the values of the NHS in general was particularly high, with some consultants pointing to the superiority of the NHS in Scotland as a major influence on their engagement. However, and consistent with the professional orientations to work of consultants and negative views of bureaucracy and managerialism, engagement with their organizations was only moderate to low.

14. One of the strongest findings was that consultants felt a marked lack of opportunity to express their ideas and feelings, and to participate in decision-making over issues that directly affected their working lives. The survey results show these aspects of voice<sup>7</sup> to be the most negative aspects of consultants' experience of work. The interview data indicated that some consultants saw this lack of opportunity to express voice as a deliberate strategy on behalf of non-clinical managers, intended to disempower consultants or avoid confrontation over difficult decisions. However, there was some variation among different groups of consultants in how they responded to the survey. For example, consultants with experience of medical management recorded significantly better perceptions of communications.

15. Despite these negative perceptions and accounts of their changing work experience, the majority of consultants regarded the NHS in a very positive light and identified strongly with the values of the NHS, which was particularly evident in the survey data. Although some consultants during the interviews pointed to other systems of healthcare as being superior in certain aspects of healthcare delivery, most of the interviews showed that consultants regarded the NHS as among the most effective systems in the world. However, it was also generally felt to be creaking under the strain of having to deal with year-on-year greater 'demand inflation' unmet by proportionate increases in resources. These pressures were often seen to arise from politicians over-promising to deliver world-class healthcare to an expectant general public, which were reinforced by local and national media seeking to increase circulation and generate political capital from 'bad news' stories about the NHS, e.g. on waiting times and hospital failures. As a consequence, a widely shared view held by many interviewees was a sense of or frustration, sometimes bordering on hopelessness, over how to make the system more effective. Few

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<sup>7</sup> Voice has been defined as the right to express opinions and have meaningful input into work-related decision-making.

interviewees had a strong sense of control over their working lives or were able to offer solutions to how to 'fix' the system, which led in some cases to reports of increased stress and/or decisions to leave their employers or to retire early. While consultants wanted to see more doctors in management, many fewer had faith that consultants in management roles were capable of changing institutions outside of their control. Instead, most consultants pinned their faith on improving the opportunities for greater consultant voice, though without much faith that greater voice and participation in decision-making would or could change the now established political and economic institutions of healthcare in NHS Scotland.

## **Conclusion**

16. Overall, our research reveals significant concerns among consultants over the impact of managerialism, bureaucratic, financial and political controls on their professional autonomy and freedom, and their evaluations of the sustainability of the healthcare system. As researchers, we could not be other than impressed with the levels of engagement that interviewees expressed about their jobs and colleagues. At the same time, however, we detected a strong note of pessimism, even fatalism, over how the healthcare system could be improved for the benefit of all stakeholders, without substantial improvements in resources allocated to the NHS in Scotland. These feelings, if left unaddressed, could have major consequences for patient care and the overall sustainability of NHS Scotland.

## BACKGROUND TO THE STUDY, RESEARCH QUESTIONS AND OBJECTIVES

### RESEARCH BRIEF

The BMA Scottish consultants committee's (SCC) motivation for commissioning this project was to "explore increasing reports that consultants feel that the authority and leadership traditionally associated with their role has been taken away from them" and that consultants feel they are subject to "increasing levels of accountability for consultants' clinical performance, but without the authority necessary to effect change". The BMA Scottish consultants committee believed that such perceptions, if well-founded and widespread, may lead to frustration and feelings of powerless among consultants and could jeopardise patient care, as was evident in perceptions of clinical disempowerment in the Mid-Staffordshire case. The SCC's stated objectives were:

To understand the extent of perceptions and emotions concerning the above issues, their nature, antecedents and consequences, the extent to which they are held by age, gender, location and speciality, the range of concerns and their coherence.

- To understand the extent to which these perceptions may have changed over time, and why changes may have occurred.
- To understand the extent to which any such negative perceptions and emotions may have impacted consultants' morale, motivation, career intentions and productivity.

To achieve these aims and objectives, the SCC commissioned a mixed-methods research project, which involved 'triangulating' (or comparing) the findings from a first stage qualitative data collection exercise with quantitative data from a survey to avoid unnecessary bias.

### THE RESEARCH QUESTION AND RESEARCH OBJECTIVES

With these objectives in mind, we have attempted to encapsulate these research aims and objectives into a central research question to guide this project:

*To what extent has consultants' experience of work changed since their first appointment and how and why have such changes affected key outcomes, including engagement, trust relations, voice and perceptions of system effectiveness?*

Answering this question has led us to formulate seven key objectives:

1. Conduct a scoping literature review of relevant academic literature, drawing on management, healthcare management and organizational theory, and relevant policy and practice-oriented literature;
2. Use this literature review to develop an exploratory framework and a set of accompanying propositions that could help explain and predict changes in consultants' work experience. This framework would include key contextual factors shaping their experience of work, key antecedents, consequences for consultants' careers, their relations with their employers, work engagement and standards of patient care;
3. Develop an appropriate mixed-methods research strategy for answering the research question;
4. Conduct a first stage qualitative investigation, guided by the theoretical framework, involving individual interviews with consultants. The first stage was to draw on qualitative sampling technique and consist of individual interviews with consultants with a range of backgrounds, specialties, years of experiences and employment in different locations and types of hospitals backgrounds, locations and specialties. The number of interviews conducted was to be determined when theoretical saturation was reached;
5. Drawing on insights from the interviews and from the literature, to conduct an online survey of all consultants in Scotland to shed further light on the research question by providing a broader picture and potential corroboration of our interview data; and
6. Produce an accessible report in line with the requirements of the SCC, including a discussion of the methodology, a full analysis of themes arising from the data collection stage, a discussion and interpretation of the data, references to other studies, and a bibliography.

## **WHAT DO WE KNOW FROM PREVIOUS STUDIES? A REVIEW OF RELEVANT LITERATURE**

Our review of relevant research has led us to consider a range of literature from healthcare management, the sociology of the professions in healthcare, organizational theory and the management of people. In undertaking the literature review we conducted a keyword search of these domains as well as using our knowledge of relevant literature from our previous research into healthcare management (e.g. Beech, MacIntosh & Martin, 2012; Howieson, 2013; Martin, Beech, MacIntosh & Bushfield, 2014; Spilg, Siebert & Martin, 2012). As a result, our work has been informed by the literature on:

- (a) the ‘deprofessionalization’, ‘re-stratification’ and ‘proletarianization’ of professional work, especially medical work, in the UK,
- (b) the causes and nature of organizational trust dynamics, and the role of organizational spaces and symbols in shaping professionals’ attitudes and behaviour,
- (c) the nature of engagement of healthcare professionals with their work, their teams, their employers and the industry in which work,
- (d) employee voice, which includes the opportunities to express opinions and participate in decision-making, and
- (e) public sector management, leadership and clinical leadership as solutions to modernizing complex systems of public healthcare. We discuss each of these in turn and attempt to combine them in an explanatory framework that has guided our research.

In the next section we define these terms in more detail.

### ***THE DEPROFESSIONALIZATION THESIS, RESTRATIFICATION AND PROLETARIANIZATION***

Over the past thirty years, there has been a wide debate over issues related to a proposed deprofessionalization of the medical profession in advanced economies such as the UK (Currie et al, 2012; Filc, 2006; MacIntosh et al, 2012; McDonald et al, 2012; McGivern et al, 2015; Ritzer & Walczak, 1988; Waring & Currie, 2009). This literature on deprofessionalization, some of which has appeared in medical journals, points to two related trends that arise from: (a) political desires to create efficiencies and control costs in the face of increasing demands from ageing populations and knowledgeable clients, well-publicised health systems ‘failures’ attributable in part to medical practice (Francis, 2012), and (b) a desire to make healthcare organizations more accountable to electorates and other stakeholders in healthcare regimes.

These trends are two-fold:

1. Doctors in the NHS are subject to greater direct bureaucratic and managerial control through so-called New Public Management, thus losing their autonomy over how work is organized, carried out and performance managed (Ham, 2014). An alternative perspective to deprofessionalization is the re-stratification thesis (Freidson, 1994; McDonald et al, 2012). This view sees control now resting with new medical elites such as medical managers or clinical directors, and bodies such as the Medical Royal Colleges and the GMC, which have assumed internal

control of the profession to ward off possible external regulation resulting from malpractice cases like Shipman and the recent Francis enquiry into the Mid-Staffordshire case (Francis, 2013; McGivern et al, 2015; Martin et al, 2015). Finally, external regulation, for example, the European Working Time Directive (EWTD), has also been enacted to control the labour process in medicine (Spilg et al, 2012).

2. The medical profession is losing its traditional status in society, power over and influence over other groups such as other healthcare occupations, patients and, indeed, society as a whole (Filc, 2006). This loss of status, power and influence is made all the more challenging because of increased expectations of doctors by patients that they are not able to meet because of resource constraints, inability to control entry into the profession and lower public perceptions of doctors in terms of status and respect (McDonald et al, 2012).

More recently, deprofessionalization has become associated with the loss of two, interconnected types of autonomy and control – socio-cultural and task-related autonomy (Numerato et al, 2013). The decline in socio-cultural autonomy is often attributed to the developing ideology of public sector managerialism, a set of ideas and a political discourse that emphasizes rationalism and standardization through accountability, transparency and constant evaluation against targets (Ham, 2014). This discourse of managerialism and bureaucracy has become pervasive in the medical profession, not only in shaping formal systems of control and clinical practice but also in shaping doctors' sense of what is considered reasonable and useful in clinical practice, e.g. during the early socialization of trainee doctors into the profession (Gordon, 2015).

Thus, the governance of the medical profession is exercised: (a) externally by non-clinical managers and the bureaucracy of control, and (b) internally by doctors whose adoption of the language and values of a managerial discourse literally leads them to become self-governing. The latter is most evident in creation of hybrid roles of clinical leaders and medical managers, whose attitudes and values are often seen to be different from their professional colleagues (Dickenson & Ham, 2008; MacIntosh et al, 2012; Spurgeon et al, 2011). This growth in medical management is sometimes referred to as a key element in restratifying the profession, especially when combined with the establishment of elite medical bodies that have taken on the role of self-regulating the profession (Freidson, 1994; Filc, 2006). Nevertheless, the literature on restratification by distributing leadership to some doctors may be misplaced in theory as well as practice (Martin et al, 2015), since much of the research on socio-cultural control through restratification has focused on how doctors have opposed and resisted the discourse and practices of managerialism and 'leaderism'<sup>8</sup> (Martin & Learmonth, 2012). This is largely attributed to doctors viewing managerial decision-making governed by a business rationale that is inimical to their autonomy rather than a medical professional rationale that doctors equate with patient care (Reay & Hinings, 2009).

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<sup>8</sup> a set of ideas and a political discourse that emphasizes the virtues and agency of leaders (as distinct from leadership) in bringing about change in organizations as distinct from management, which is assumed to focus on creating stable and efficient organizations.

In contrast to socio-cultural autonomy, task autonomy in a medical context refers to doctors' control over clinical practice and their rights to exercise expert knowledge. Traditionally, managers have avoided incursions into these areas traditionally regarded as the doctors' prerogative. However, managerial attempts to exercise direct control over clinical practice through the issue of targets and guidelines, and the monitoring and evaluation of these, has become much more widespread and intense, arguably more so in NHS Scotland than the NHS in England which has relied to a greater degree on market control (Bevan, Karanikolos, Exley, Nolte, Connolly & Mays, 2014). This process is sometimes labelled proletarianization, which refers to trends in the de-skilling of expert work in general (Braverman, 1974) and to medical work in particular, through attempts to rationalize and routinize doctors' jobs (Oppenheimer, 1971) by the introduction of knowledge management systems (Waring & Currie, 2009), new appraisal techniques (McGivern & Ferlie, 2007) and so called 'big data'. As a consequence, task control has often been met by doctors' direct resistance, ignoring rules or defeating information systems, or attempts to negotiate and re-interpret new rules and standards in areas such as clinical governance. Allied to these changes, doctors are also subjected to material and symbolic changes in their jobs, two of which are the role of space and dress codes that can be interpreted as attempts to reduce their status and blur traditional professional boundaries (Siebert et al, 2014). Finally, it is also argued that doctors are increasingly willing to take collective action, which hitherto had been regarded as the recourse of non-professional groups to task control and as a signifier of proletarianization.

These ideas were closely related to the SCCs original brief concerning increasing accountability of consultants for improving the healthcare system in Scotland without the necessary authority to do so. Thus we chose to explore them in detail during both the qualitative and quantitative stages of the research project.

## **TRUST DYNAMICS**

The de-skilling thesis is linked to trust dynamics in organizations. Four decades ago Alan Fox (1974) cogently argued that low trust initiatives by employers, characterized by close control of the employees' work through supervision and increased bureaucracy, led to low trust responses by employees in the form of a decline in employee loyalty and commitment to their employers. In turn, employers responded with further low trust controls, which resulted in a continuous low trust dynamic (Siebert et al, in press). However, Fox also argued that professionals were distinctive among occupations because of their expert knowledge, personal and creative skills. As a consequence, and because employers often lacked the knowledge held by professionals, they were required to implement high trust initiatives by giving professionals substantial autonomy over how their work was carried out and, in certain cases, determining the criteria for effective output. In return, employers hoped to benefit from high trust responses in the form of professional employees' commitment and self-control. So high trust dynamics were associated with high discretion work, characterized by personal commitment of

employees to the values of the organization, low task specificity, relative autonomy, open communication, supportive rather than directive leadership, and freedom from close supervision and impersonal rules. In a high trust dynamic inadequate performance was treated as a 'learning opportunity' rather than as a disciplinary situation. This picture of high trust dynamics was one that typified the health service decades ago, but is seen to be rapidly changing with the onset of New Public Management, managerialism and leaderism. Thus we wished to explore these potential changes in this research project.

Although most studies on low-trust relations related to an employment relations' context in 1970s and 1980s Britain, we saw *prima facie* parallels with the situation of consultants. We focused specifically on trust in both qualitative and quantitative stages of the project; for example, during interviews we asked consultants about any changes in trust relations they might have observed during their careers. To investigate intra-organization trust in the survey, we applied the standard trust measurement scale proposed by Mayer et al (1995), which, translated into a medical context, examined the extent to which consultants found their managers as competent, honest in their dealings with medical staff and willing to prioritize consultants' interests in patient care.

### *DIFFERENT LEVELS OF DOCTORS' ENGAGEMENT*

Although the idea of employee engagement has been criticized by some academics for pouring 'old wine into new bottles', it has become a widely accepted term in practice and among management academics to warrant inclusion in an investigation of doctors' experience of work. The concept of engagement has been largely restricted to measuring employee attitudes to organizational engagement and to job satisfaction. Our recent work on this topic, however, has made an important distinction between four different foci of engagement or aspects of employment with which employees can become engaged (Martin & Groen in't Woud, 2011). These are: (i) their immediate tasks or work, (ii) with each other (e.g. the clinical team and professional colleagues), (iii) their organization, and (iv) the industry in which they work. All four levels are independent and have different impacts on key outcomes but also interact to produce an overall sense of employee engagement.

Doctors have been found to be highly engaged in their work but not always engaged with their employing organization or with each other in clinical teams (Gittell et al, 2010; Martin et al, 2015). Such a pattern of engagement can result in high turnover, failures in team-working and lack of advocacy/ organizational citizenship. Examples of these outcomes are evident in industries as diverse as professional football, higher education, law and financial services. Interestingly employees can also become over-engaged with their work and their organizations, leading to burnout and a failure to see problems emerging. The key point here is that it is necessary to measure each of these different foci of engagement and their interactions to understand how they impact key outcomes. These lines of questioning were an important line of enquiry in the interviews, which we



followed up in the survey using established scales on job engagement in healthcare (Schaufeli & Bakker, 2004), relational coordination as a proxy for engagement with each other (Gittell, et al), organizational identification as a proxy for engagement with the organization (Edwards & Peccei, 2007) and a single item on engagement with the values of the NHS.

### ***LACK OF EMPLOYEE VOICE***

Much of the early work on employee voice is based on the seminal work of Hirschman (1970: 30), who saw voice as ‘a natural human tendency to express discontent by complaining, protesting and generally “kicking up a fuss”. Since then the boundaries of the topic have been extended. For example Budd (2014: 477) sees employee voice as “the right to express opinions and have meaningful input into work-related decision-making, which includes individual and collective voice, union and non-union voice, and voice mechanisms that cover not only employment terms, but also work autonomy and business issues”. As such it is concerned with whether to speak up or remain silent (Hirschman, 1970; Rees, Alfes & Gatenby, 2013), whether voice is exercised in a socially constructive manner to improve decision-making (Tangirala & Ramanujam, 2008) or as retributive justice exercised by employees over managers and the organization (Klass et al., 2012), and the extent to which employees enjoy democratic rights in their organizations and are able to exercise a degree of control or task autonomy in their work situations (Wilkinson & Fay, 2011). There is a considerable literature on this topic (Farndale et al., 2011), particularly concerning employees’ motivations to express voice, and the situational factors that determine largely individual behaviour, (Klass et al., 2012; Morrison, 2011). Outside of the psychology-dominated literature, considerations of voice are normally made at the collective level and linked to employee participation in decision-making (Budd, Gollan & Wilkinson, 2010; Wilkinson & Fay, 2011). This literature has distinguished between direct, indirect and hybrid voice channels, with the last of these represented by managers’ attempts to secure employee voice through union or representative channels (Bryson et al., 2006).

Again, a lack of voice seemed to us to be a natural corollary of deprofessionalization and a factor close to the brief. This led us to raise the issue of voice in the interviews and to further explore it through the survey.

### ***INSTITUTIONAL LOGICS AND GOVERNANCE OF HEALTHCARE SYSTEMS***

Institutional logics, which can be described in lay terms as rationales, have become a widely accepted explanation in organization studies of why organizations, industries and

societies are resistant to change and rational analysis. Such logics or rationales are believed to govern decision-making, methods of organizing and methods of evaluation at a societal level and in organizational fields such as healthcare (Kitchener & Mertz, 2010). At a societal level, these logics are depicted as those of the market (economic value), corporations (growth), the democratic state (accountability to the public and governments), the family (kinship ties), religion (non-secular values) and, most importantly in our case, those of the professions (client values and ethics). Much of the research in this area has focused on how tensions between these, often-competing, societal logics influence how organizations and occupational groups make sense of their thoughts and actions (Thornton et al., 2012) and how these tensions can either reinforce or change institutions at different levels in, for example, the healthcare system. Thus, Besharov and Smith (2014) have analysed conflict according to whether logics are central and compatible with an organization's functioning, a point we take up in the discussion.

Professions such as medicine and those within medicine have been characterized by a concern with legitimacy for their survival and/or dominance, by which we mean actions that are "are desirable, proper or appropriate within a socially constructed system of norms, values and behaviour" (Suchman, 1995: 574). Historically, a medical-professional logic has been the dominant legitimating rationale (Reay & Hinings, 2009), in which the doctor-patient relationship and patient care has traditionally governed all decision-making, and organization and evaluation of work, including the legitimate behaviour of both doctors and patients. More recently, healthcare systems in the UK have been influenced by a business-related logic, which includes financial governance, managerialism and bureaucracy, and the rise of so-called 'leaderism', a discourse that elevates the values and practices of leaders (rather than leadership) to system effectiveness and reform (O'Reilly & Reed, 2010).

In part to make such logics more acceptable to consultants, the NHS has sought to incorporate doctors into decision-making at all levels in healthcare management (Ham, 2014; Martin et al, 2015). Furthermore, in publically owned systems such as the NHS there is also an increasing influential political/democratic logic, which has emphasized professional accountability to political leaders. The combined effective of a clash of logics in the Canadian healthcare system has led to what Reay and Hinings have declared as a typical 'uneasy truce' between medical professionalism and business-like healthcare. This truce has resulted in hybrid healthcare organizations and often conflicted job roles such as medical management, in which neither side trusts the other and both continue to assert the basis of their legitimacy. As we have noted, political rationales and values are also an important influence in the UK NHS, especially in the more corporatist Scottish NHS (Bevan et al., 2014), which we also explored during the interviews.

One important line of enquiry has been the response of the medical profession to these tensions generated by multiple logics. Evidence suggests that doctors have sought to protect their positions by engaging in what has become known as 'institutional work' aimed at maintaining and changing the established culture and practices of healthcare governance (Reay & Hinings, 2009). This institutional work has involved a four-fold response from the medical profession: (1) to agree to disagree but work together with

managers to challenge government controls; (2) to withhold formal input into decision-making but provide informal advice where appropriate; (3) to work together with managers to challenge or work around government control; and/or (4) to work together to innovate in limited 'experimental sites' of cooperation. Thus, the influences of competing logics and the views of consultants on the kinds of institutional work that they regard as important were an important line of enquiry in our interviews and survey.

## *FRAMING THE STUDY*

We integrated these ideas from our literature review to produce a framework for the study (see Figure 1 below). From this framework, we derived a number of tentative propositions that we used to guide our qualitative and quantitative data collection:

1. Consultants in NHS Scotland increasingly interpret decision-making as governed by business-related and political rationales rather than a medical professional rationale (Reay & Hinings, 2009), which previously dominated the running of the NHS (Currie et al, 2012).
2. Consultants' interpretations of the logics of decision-making and the actions that accompany them would result in a significant and widespread sense of deprofessionalization and proletarianization among them. These would be manifested through perceptions of:
  - (a) increasingly challenging patient expectations and a breakdown in trust and respect for doctors,
  - (b) heightened perceptions of unnecessary bureaucracy and a misplaced non-clinical managerial agenda,
  - (c) incipient self-regulation by elite medical bodies and elite medical managers, whose work is seen as largely inconsequential or, in some cases, harmful to health care system effectiveness by the majority of doctors,
  - (d) deskilling and routinization of work, including encroachment of traditional medical work by other clinical and non-clinical professions,
  - (e) symbolic attacks on the status of consultants in the form of single-status requirements, e.g. dress codes and individual offices, and
  - (f) an increasing willingness among consultants to take collective action in pursuit of grievances.

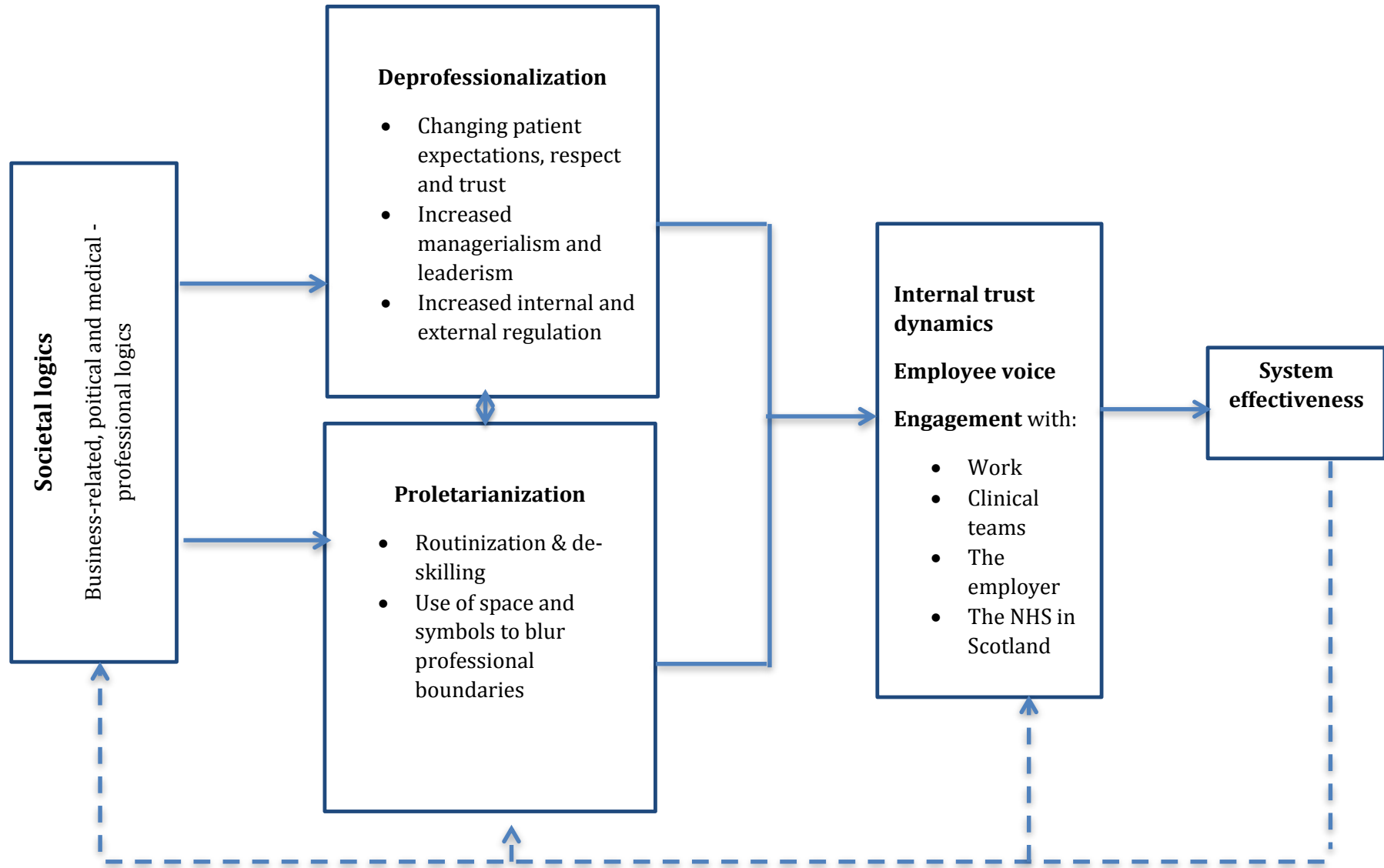
Perceptions of deprofessionalization and proletarianization among consultants would be associated with a sense of low trust dynamics among consultants, managers and the Boards (Siebert, Martin, Bozic & Docherty, 2015), their levels of engagement in their work,

clinical teams, the organization and the NHS in Scotland as a whole, and negative perceptions of having a meaningful input into decision-making and ability and willingness to exercise voice in a pro-social manner.

3. Low trust dynamics, lack of engagement and lack of voice would be associated with perceptions of system ineffectiveness, for example in patient care, exit of consultants from the system, and efficiency and effectiveness.

In our findings section we assess how our data confirm or refute these tentative propositions derived from the extant literature. However, before doing so, it is necessary to set out and justify how we collected and analysed these data and point out the limitations in our study.

**Figure 1: The potential causes and consequences of deprofessionalization and proletarianization among hospital consultants**



## METHODOLOGY

### **The rationale for the mixed-methods approach and mode of analysis**

Our research approach was essentially pragmatic and adopted a mixed-methods research design (Bryman, 2006). In this case, our mixed methods approach had a two-fold function. First, the *exploratory sequential design* (Cresswell & Plano Clark, 2007) meant that qualitative data collection and analysis preceded the quantitative stage. Consequently, we used a sequential model in which the results from the interview stage were used to help develop the questionnaire, not only in designing items for it but also in informing the choice of issues to be further investigated.

At the analysis stage, and where appropriate, we have privileged the interview data over the survey data because these data tend to provide greater insight and allowed participants to reflect on and theorize their own views and behaviour. However, the survey data was intended to provide breadth as well as depth on some issues, so at the point of interface, i.e. the stage of integration in which the quantitative and qualitative strands were mixed, we delayed our full interpretation of the data sets until we had analysed both. Thus, we report and draw conclusions and inferences that reflect what we learned from comparing or synthesizing the results from the two strands of the study.

### **The first stage**

The first qualitative stage involved in-depth interviews with 68 consultants in Scotland during the period May to September 2014. Most of the interviews were face-to-face, however Skype or phone was used in a few cases. Interviews were semi-structured, typically taking 1-1.5 hours, they were audio-recorded and subsequently transcribed and analysed using the software package, NVivo. Our questions (see Appendix 1) were informed by our initial review and knowledge of the literature relating to the deprofessionalization of doctors (see Figure 1 for a summary of the conceptual framework underpinning the study). We were interested in how consultants accounted for the changes in their experience of work over the course of their careers, their views on deprofessionalization, proletarianization, trust dynamics, voice and engagement, and the relations between them. Our analysis of the interviews sought to condense the material in the transcripts into the underlying themes emerging from the data and how these themes mapped onto our framework in Figure 1.

Our approach to the interview sampling, in contrast to the methods adopted in the natural sciences, was not governed by a need for representativeness in a strict statistical sense, nor the need to generalize to the population of consultants as a whole in Scotland. Instead, and in line with most interpretivist qualitative, we were more concerned to explore and understand in depth how consultants interpreted and gave meaning to their experiences. Nevertheless, to gauge how participants' interpretations of their social world might vary, we attempted to speak to consultants in all boards in Scotland, in all types of hospitals, consultant specialties and age ranges to address potential concerns about

representativeness. The number of interviews conducted was also guided by theoretical saturation, which applies when interviewers feel they are learning less and less from each additional interview. Initially, interviewees were selected from a BMA database of consultants in different Boards in Scotland. This group accounted for slightly more than half of the final sample. These interviewees helped enlist colleagues in their Boards who were willing to be interviewed, especially in specialties and career stages that were underrepresented in the initial sample. Finally, to mitigate sampling bias as best as we could, we sought interviewees who were neither initial volunteers nor volunteers secured through BMA contacts to assess whether their views were different from earlier interviewees.

## **The second stage**

The categories emerging from the interviewees' accounts were used to inform the second stage of the data collection. Drawing on themes from the literature and emerging from the interview data we designed an online survey, which is closer to the methods adopted by the natural sciences in its assumptions and approach to understanding social phenomena. This survey consisted of 53 questions, divided into eight sections, followed by six questions related to the demographic profile of the respondents (see Appendix 2). The survey was piloted on a group of consultants, who provided extremely useful feedback that led to a revision of some of the language and categorization used in the survey. The revised survey was distributed online to 3742 consultants using the BMA's database, via an email invitation from the BMA and the research team. Potential respondents were invited to use a web link to access the survey. A reasonably good response rate for online surveys of 28.6% was achieved (Nulty, 2008) with 1058 consultants completing the questionnaire by the due date. Such a response rate is open to non-response bias, so we attempted to assess this by carrying out a wave analysis to determine the extent to which 458 respondents to the follow up email differed in response patterns and demographics from the first wave of 600 respondents. This analysis showed that mean responses across the two waves of response did not vary significantly, apart from views concerning clinical leadership in the second wave were significantly more negative ( $P < 0.01$ ). This response rate lends credibility to the survey. However, it was not possible to test whether respondents were representative of the target population as summary statistics for the demographic variables were not available from the database (see Appendix 3 for a breakdown of demographic responses). Hence, care must be taken when interpreting the results of the survey.

In the findings section we typically report the means for the 5-point scale questions and the variation among mean scores for specific demographic groups where these were significant using standard statistical tests (cross-tabulations tests and one-way analysis of variance (ANOVA)). We also performed a confirmatory factor analysis on our data to assess the construct validity of key elements of our theoretical framework, which are reported in the findings where appropriate.

In addition to the quantitative data from the scale items and demographic question, there were 430 free text responses, with the majority of these providing reflective and sometimes lengthy accounts of respondents' positive and negative experiences. Once

again, these have been subject to text analysis and have contributed substantially to the overall picture from our mixed method data collection.



## FINDINGS

### DEPROFESSIONALIZATION

Our review of the literature on the deprofessionalization of doctors over the last four decades highlighted three distinctive but related components: (a) changes in the public perceptions of doctors and heightened expectations of the healthcare system by patients and the public, (b) increasing bureaucracy and managerialism, and (c) increased self-regulation by elite medical bodies and the incorporation of doctors into management.

#### CHANGING PATIENT EXPECTATIONS, RESPECT FOR CONSULTANTS AND TRUST IN THEIR JUDGEMENT

The changing expectations of patients and attitudes of the general public towards doctors and the healthcare system has been seen as raising questions over the professional expertise and status of doctors in society (Numerato et al, 2012). Thus, we were interested in exploring this dimension of potential deprofessionalization during both stages of data collection.

- **The Role of Patient Expectations**

The interview data suggested that patient expectations were seen as a challenge to consultants' experience of work, with the majority of interviewees highlighting the strain placed on them to meet expectations, often encouraged by politicians to 'want it now and want to be seen more quickly'. These qualitative findings were borne out by the survey in which 69% of consultant respondents agreed or strongly agreed that patient expectations outstripped resources available to deliver patient care – a finding that did not vary significantly across demographic or specialty groups.

The following two free text quotations illustrate these sentiments well, while an extract from an interview highlighted the role of the media in shaping negative perceptions, a relatively common theme in the interviews:

*I have recently had thoughts of leaving the profession. The expectation of patients is overwhelming and encouraged by irresponsible politician soap-box promises (Free text comment).*

*Unrealistic targets set by Government in constrained financial circumstances has led to.... a culture of unrealistic expectations for the*

*public. In that sense, although I sound critical of board managers, I'm also sympathetic to their situation (Free text comment).*

One consultant summarised the views of many others by pointing to the role of media in raising patient expectations:

*The public's perception of medicine has changed dramatically. They no longer hold the medical profession in the same respect they did. There's no doubt about that. And I think a lot of it's to do with the media, I think, sets unrealistic expectations of what medicine can offer. ...There's a lot of information out there, and patients are a bit – much better informed, perhaps, than they were. And there's nothing wrong with that. But I think their expectations of care ... before, you might have, you know, said to a patient that, "There's nothing more I can do about it," and they would, sort of, say that, "Thank you, Doctor. You've done your best," sort of thing. But now, they challenge you, as to why they've done so poorly ...it's a lack of recognition for the reality of what medicine is. It's not perfect, and it's never going to be (Surgeon).*

However, while the survey data highlighted the challenging nature of patient expectations, most interviewees tended to accept these as a given in a democratically-controlled but resource-constrained service or, at least, were equivocal about them:

*I think there are higher expectations and of course we have to try to meet reasonable expectations but it is in cases where expectations are not raised (consultant emphasis), which are a greater source of difficulty (Free text response).*

*It wasn't a negative thing it was quite a positive thing I felt. Generally, I think they had a very high expectation and I don't mind that. I think that the whole point of being a doctor is that you explain what you're able to do and you do it openly and honestly that's what we've got to do and you need to make that very clear. So I didn't mind they had very big demands and they were unrealistic but that's the point of being a doctor is that you can at least educate people as to what's available and what you're able to do and if you can't help them then you would try and find somebody who can and if nobody can help them then that's how it is and you can't change reality (Surgeon).*

Some doctors pointed out that crucial factors such as the patient's age were often taken into account in deciding on the course of treatment, which patients and their families found hard to accept:

*There has been some [changing demands and expectations from the public] especially in relation to older patients. There is now an expectation that we investigate issues more in older patients, even when they wouldn't be suitable for an operation or treatment wouldn't be in their best interest but their relative is keen for 'everything' to be done. That has been a slow rather than dramatic change in what the patients (and their relatives) expect. I think we need to work with the GPs to work out more sensible referral criteria, for example, if a patient is 40-50 with these symptoms they should be referred or if they are healthy and 70 then they should be referred but if they are 90 with multiple physical and mental comorbidities it is not always in their best interests to be referred for tests when there is no viable solution for them (Surgeon).*

The following quotations highlight different aspects of how consultants viewed the legitimacy of patient expectations and their causes, which included family members' roles in shaping expectations, self-diagnosis through the internet, and, most importantly, patient demographics, where better off, younger or more educated patients tended to be more challenging:

*I don't think a significant shift, I think patients are more involved with their care than they used to be and I think that's a good thing ... patients can now get access electronically to their medical records and results and it's password protected so if they have internet access at home they can access the results and letters on their home computer so therefore they're more involved in their own care. (Free text response).*

*I think patients do, yes they do expect more and that's good ... an older patient is more likely to take the attitude you're the doctor that's what you're paid for (so) I want you to take the decision and tell me what to take. A younger one will want to be fully involved in the decision making and weighing up the risks (Psychiatrist).*

Finally, some interviewees also claimed that new generations of patients had come to take the NHS for granted, as the following two quotations illustrate:

*I think that expectations have gone up because I do go to other countries to operate with them as a guest operator both in Europe and outside Europe, but my impression of things in the UK, which includes the English and Scottish systems, is that patients take the NHS for granted...and that it has to provide the best care in the world, which I think the NHS is doing (Surgeon).*

*I think the NHS is one of the valuable institutions in the world and I think that looking after the NHS should be of the highest priority in Britain. Having worked in healthcare systems that are not so altruistic and are*

*incredibly harsh, so to say the patient I'm sorry you don't have money to get the leg prosthesis or a heart operation you'll have to go home now it is a terrible thing. It's a terrible situation to be in and I would like to have more positive acknowledgement of how important the NHS is on every level. To the public, to the work force because once it's gone it's gone and I think that disempowering doctors is helping to lose it... I don't know how that message gets across to the public but there are so many negative publicities about the NHS is failing and so few publicities about what a fantastic service the public gets. (Surgeon)*

However, patient attitudes were found to vary according to postcodes, especially in areas of inner city deprivation, where patients had very low expectations of the healthcare service available to them:

*There are higher expectations with respect to accessibility to consultant time but I really do find that within the past year that has been dramatically different from one side of the City to the other, so I do not think it is only time based...I would say in poorer sides of the City there is less of an expectation to direct access to consultant time, to consultant updates and so on. In more affluent areas of the City I find that is more the case; it is not to say that those expectations are wrong, but they definitely differ considerably (Physician).*

- **Perceptions of respect and trust in medical judgments and ability to treat patients well**

We were also interested in how consultants viewed the degree of respect in which they were held and patients' trust in their judgement. These are two key elements in the literature on deprofessionalization, both of which relate to changing expectations. One of the most striking findings from the survey responses, also evident in our interviews accounts, was that consultants felt they enjoyed high levels of respect and that patients had high levels of trust in their overall competence. Thus, the survey data pointed to very high levels of agreement/strong agreement with the relevant items in the questionnaire – that patients generally showed respect for consultants (88.3%) and that patients generally trusted their judgments and ability to treat them effectively (93.7%). On both counts, surgeons and physicians working in women and child healthcare were significantly more likely to agree/strongly agree ( $p < 0.01$ ) with these items, while investigative consultants were significantly less likely to agree/strongly agree ( $p < 0.01$ ).

Our data indicate that consultants' interpreted patients' trust in the medical profession to be strong. Even post-Shipman and 'Mid Staffs', it was still the view of most consultants that the profession was trusted by the general public and patients, as the following two quotations illustrate:

*We maintain our patients' respect and communicate a desire to care for patients despite our management environment, not because of it (Free text response).*

*Patients will sue more readily and complain more readily but otherwise patients I think still want to have special relationships with their doctors and still trust the doctors. Patients will come into your clinic frightened or in pain or with something that they really don't want to have and they still trust you to deal with this. So although complaints have definitely increased ... I still find my patients tremendously supportive ...I don't get satisfaction from a relationship with management and politicians, I get a satisfaction from my relationship with patients. (Surgeon).*

Indeed, views were sometimes expressed that patients held a surprising degree of respect and trust in certain types of medical judgement. As one senior consultant explained in relation to patient trust in his own profession:

*In my view, it's usually positive. So what I think is that doctors are still heard and held in great regard by patients. The belief that patients have in us is exceptional and probably more than is accurate [laughter] in some senses and that really works, but... you know, if you're being honest and transparent about it, a lot of what we do is placebo effect, so a lot of medications we give, a lot of the therapy interactions we have completely rely on that really positive regard that they have for us. Trust. So, the bottom line is, they get better but a lot of that is because they believe in us, we'll make them better (Psychiatrist).*

Where challenges did arise, consultants' accounts stressed that these were limited to demographic differences, such as younger people, and to an 'end of deference', most evident in certain affluent postcodes:

*There is an element of distrust (of doctors), but I think that's a small element. I can, again, only speak from my experience. I work in a very specialised, very hyper acute specialty... and we find in that sector that the vast majority of parents do have trust, they may have questions, they may have comments, they may have criticisms of us, but generally they have trust in us (Surgeon).*

*They're kind of very respectful towards the doctor...we have a good standing with older people... The younger people – that's a different story I think (Physician).*

*By and large I think patients still value the service we provide and still respect your opinions and expertise...Umm, some patients are more*

*informed, I don't see that as a bad thing. Unfortunately, some of them are misinformed and it tends to be the more intelligent ones...who think they know what's best for them (Surgeon).*

Challenges were also seen to be a result of comparative expectations. Thus, better-informed patients used the different procedures and practices among Boards in Scotland as a method of questioning consultants' judgement.

*(In response to a question on trust) A slight change but not too much in anaesthesia I think more patients are really well educated, they've got access to the internet and Google and have a bit more medical knowledge and are probably slightly more likely to ask questions but I still find the average (regional) patients are very trusting and tends to take the doctor's point of view if and when we offer them advice they still tend to go with that so I've not seen any major sea changes in that respect (Anaesthetist).*

Two related issues were mentioned in a more negative light, which was the risk of complaint and possible litigation. Several interviewees raised the growth of 'the no win, no fee' culture, and the additional pressure this development puts on them and on the NHS. The survey results showed that 53% of consultants agreed or strongly agreed that they had 'one eye on potential complaints when treating patients, a level of agreement that did not vary significantly across demographic groups.

Several interviewees, especially surgeons, also suggested that this was one of the most stressful part of their job, given that the system often 'hangs them out to dry' and encourages clinicians to apologise even when they believe that they had provided adequate care:

*This also leads on to complaints. This is horrible for consultants, very upsetting. Getting a complaint can upset your day or week. The complaint may be related to bad outcomes, rude doctors or nurses, or perceived to be rude doctors or nurses, and very occasionally medical error, but as the consultant it is your responsibility to deal with it and it is a horrible process that makes you feel guilty even when there is nothing that you could have done (Surgeon).*

Complaints were often made about "softer perception-based issues" rather than hard medical facts, for example, the "rude doctor" or nurse:

*Probably one of the most stressful parts of the work is dealing with complaints. You know, especially, because the way the NHS complaints service works, they're not there to defend the Clinician. They're there to minimise any problems for the (name of NHS board) So often, you know – they will issue an apology, often, when the Clinician may feel that's*

*inappropriate. So, when the Clinician feels they've done nothing wrong, you know, you end up having to apologise. And the other thing is, you know, with patients – you know, patients can come in and they can write a letter, sometimes a very personal, and very, you know – and you've got no comeback. You can't write, "Well, this patient was rude and aggressive and, you know, never listened to anything I said." ... The reaction has to be an apology (Surgeon).*

## **INCREASING BUREAUCRACY AND MANAGERIALISM**

Our second strand of enquiry into deprofessionalization focused on increasing levels of bureaucracy and managerialism in the NHS to managing performance. The interviews, survey and free text responses in the survey showed these factors combined to be the single most important factor associated with expressions of negative work experiences by consultants. These negative experiences were evident among all demographic groups in the interviews, although the survey showed early career consultants to see them as less harmful. We attempt to distinguish between increasing bureaucracy and managerialism in the next section, although in practice interviewees saw them as interrelated.

### **INCREASING BUREAUCRACY**

The survey data showed this component of deprofessionalization to be one of the most important negative aspects of consultants' changing experience of work. These data were also supported by our interview analysis, which showed that consultants referred to increasing bureaucracy as the most frequently cited negative comment. In the survey (see Table 1), 80.6% of respondents agreed/strongly agreed that their jobs had become increasingly governed by bureaucracy (e.g. performance management through target setting, form filling, etc.), a figure which did not vary significantly across demographic groups, apart from consultants with four or less years of experience who were significantly less likely to inclination to agree with the statement ( $p < 0.01$ ). Moreover, 58% of respondents agreed that most of the bureaucracy was unnecessary and got in the way of patient care, with only 16% disagreeing. This finding did not vary significantly with years of experience as a consultant or experience in clinical leadership. Finally, only 26.7% of respondents' agreed/strongly agreed that bureaucracy was an essential, if not always, welcome element of the jobs:

**Table 1 Consultants' views on the bureaucratization of their work**

Item	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Mean
My job has been increasingly governed by bureaucracy since I first became a consultant	1.68%	5.68%	12.01%	34.36%	46.28%	4.18
Most of the bureaucracy is unnecessary and gets in the way of delivering effective patient care	1.58%	14.43%	25.88%	40.40%	18.06%	3.59
I see bureaucracy as an essential, if not always welcome, element of my job	11.73%	35.38%	27.19%	25.12%	1.58%	2.68

Again, however, early career consultants were significantly more likely to agree/strongly with this statement ( $p < 0.01$ ), a view which is illustrated in the following quotation from an early career consultant:

*I must say it – it [bureaucracy] doesn't impact very badly. Most of the... form-filling, and paperwork... that I end up having to do does seem to be fairly, fairly appropriate. In my day-to-day working, I don't feel it's affecting me badly – or at least not, in terms of unnecessary stuff (Physician).*

Many interviewees accounted for increasing and unnecessary bureaucracy by referring to the impact of events such as the Shipman and the Mid Staffordshire inquiries, as this next quotation illustrates:

*(when referring to a question on appraisal) ...every single time the same element creeps in, so I'm a little bit cynical about it and the reason it was introduced was to stop the Harold Shipman's of this world, again, but in reality, he...was a one-off psychopath hopefully and it's, you know, whatever the system is being used, appraisals won't stop another Harold Shipman (Surgeon).*

Others spoke of political desires for greater efficiency and meeting patient expectations, and largely politically motivated target setting on issues such as waiting times, etc. The quotations below highlight some of the issues raised:



*I have been a consultant for 19 years. During that time I have seen management expand through self-perpetuating bureaucracy while the position and role of the consultant has been diminished by underfunding, inappropriate policies and ridiculous diktat. The role of the consultant is clearly viewed by management to provide patient care on a shoestring, to do so unsupported, and to take the blame when patient care goes wrong even if the cause is faulty management (Physician).*

*(referring to manipulation of waiting lists) Yes, and...well we know there are patients on waiting lists who have been contacted at short notice to say, "You can't have your operation in a (hospital X), but you can have it elsewhere (hospital Y)", and sometimes they're contacted as soon as they're put on the waiting list, which doesn't make much sense. You can't say "Well, I've been put on a waiting list for two days and I've already been phoned about having my procedure done in (name of city A) or (city B) or somewhere". That's...manipulation... (Surgeon)*

*Goals are very much target driven and not patient-centred. Consultants have lost the ability to rationalize and prioritise patient care (Physician)*

*Increasing bureaucratization has actually led to more and more difficulties because the decisions made by bureaucrats are so far away from the difficulties that patients and clinicians face. (Psychiatrist).*

These comments above highlight the perceived distance between the day-to-day work of clinicians and the world of political performance management, target-setting and managerial agendas. One physician encapsulated this sentiment when referring to 'black and white' targets and the need for 'areas of grey' within practice:

*I think, definitely, there is increased bureaucracy. ... and trying to find a way through it is – is no easier than it ever has been. There's nobody, whose job it seems to be, to signpost clinicians, as to how to get through all the bureaucracy. I think the targets do put pressure on systems, because it's such a headline – such as the four-hour wait in A and E, and the wait for out patient appointments. But when the targets are set, there's often a bit more detail that makes it less black and white, and a bit more shades of grey, which is much more useful. But actually, the way they're then implemented is very much just looking at the headline. (Physician)*

While a minority of consultants accepted that target setting in theory and, in some cases, in practice might look as if it could improve overall efficiency, most focused on the unnecessary or dysfunctional aspects of target setting in general, especially waiting times

and the ways in which these targets were implemented. Targets were often seen as a blunt instrument for reducing the autonomy of doctors to treat those people who they judged to need urgent treatment. The following quotes capture the views of many consultants:

*Some of what blurs that is the waiting time target...there is a struggle between patients who could wait six to eight weeks but have to be scanned in four weeks (because of targets) and patients who need to be scanned today or tomorrow but we don't have space because we're filled up with patients who could have waited a couple of weeks (Radiologist).*

*...(referring to targets) I mean it puts our system under strain, it puts undoubted stresses on our admin staff who have to try and find appointments for patients. And they're told there are obviously new patient limits, waiting time limits. So they come to us and we try and allocate them on an individual and clinical need basis, so although management are saying they need an appointment if we can't find an appointment we have to try and allocate it on a need basis, a clinical basis rather than an appointment basis which causes a little bit of conflict sometimes. What we've also had to do is we've had to because the pressures are on new patient appointments. We've struggled to fill in our return patient appointments, which are actually a big workload in (specialty) medicine (Physician).*

*It (referring to change) really started as a registrar, but as a consultant things became much more target driven and we had no input into what the targets were. The targets didn't necessarily seem sensible or beneficial for patients. At the same time the amount of support in terms of secretarial support and middle grade supports reduced significantly. In some ways at times it wouldn't be unusual necessarily to be doing both the work of a registrar and a consultant (Surgeon).*

Most interviewees stressed the high proportion of their time taken up by paperwork and dealing with bureaucratic systems. There was an overall sense that there was less support, especially secretarial support, to help cope with administrative duties, as well as less junior medical support. An anaesthetist's views summarized the feelings of most interviewees concerning the unnecessary nature of form filling:

*I think there must be this big black hole in space where all the audit forms go that are never looked at and all the computer figures that are never looked at you know and the triplicates and quadruple things for this ...the big thing right now about risk management OK and when I work in theatres as an anaesthetist there's about twenty forms and what happens is you therefore can't prioritise what the risk is (Anaesthetist).*

In a similar vein, another interviewee commented:

*(the) use of electronic patient record is time consuming particularly when trying to access previously documented information. Progress, for example, in the form of the Mental Health Act 2003 has resulted in a substantial increase in paperwork and meetings. The use of e-mail means vast amounts of information is sent to me often as attachments for meetings and for consultation that I do not have the time to fully digest or respond to. It often feels that what is expected of me is not possible in the time available, that more tasks are added without anything being removed (Physician).*

A minority of consultants, however, saw positive as well as negative features of bureaucratic control. For example, as one interviewee explained, aspects of medical work had been improved by the introduction of new technologies such as electronic patient records:

*Oh absolutely yes, yes but at the same time that that's happening from the point of view of me having to fill in spread sheets for cancelling clinics or whatever there's also been a massive improvement in the access to electronic data from a patient point of view so in clinic we've now, well there's a few problems with it but on the face of it if you compare my access to patient data when I became a consultant to now it's unbelievable I mean I could have never dreamt that I would be working in an environment where I could just log in and get all the radiology pictures up on screen and you know get all the blood results, (Physician)*

### **INCREASING MANAGERIALISM**

Both the survey and interview data showed that the growth, power and influence of non-clinical managers were seen to be strongly associated with feelings of deprofessionalization (see Table 2). Thus, 80.36% of survey respondents agreed/strongly agreed that non-clinical managers had assumed a bigger role in decisions that affected consultants' working lives, while just over 56% agreed/strongly agreed that the increasing influence of a managerial agenda had made it very difficult to do their jobs effectively. Not surprisingly, however, early career consultants ( $p < 0.05$ ), who had been socialised into the changing healthcare system, and consultants with medical management experience ( $p < 0.01$ ), were significantly less likely to agree/ strongly agree with negative items related to non-clinical management interventions.

Confirmatory factor analysis showed negative attitudes toward non-clinical managers were highly loaded onto a factor that closely resembled our original concept of

deprofessionalization. This analysis suggests that there is close correspondence between our definition of deprofessionalization and consultants' views on the growth of non-managerial power and influence, non-clinical managers' lack of understanding of the work of consultants, and consultants' low levels of respect for non-clinical managers. 63.64% of respondents agreed/strongly agreed that non-clinical managers had too much influence over service delivery, only 15.52% agreed/strongly agreed that non-clinical managers had a good enough understanding of consultants' work to exercise their responsibilities effectively, and only 39.35% agreed/strongly agreed they had respect for the non-clinical managers and the work that they did. Again it should be noted that consultants with experience of medical management were significantly more likely ( $p<0.01$ ) to hold more positive views of non-clinical management and their role.

**Table 2: Consultants' Views on Non-clinical Managers**

Survey Items	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Mean
Since first becoming a consultant, non clinical managers seem to have taken a bigger role in decisions that affect my working life	0.74%	6.98%	11.92%	33.43%	46.93%	4.19
The increasing influence of a managerial agenda in my organizations has made it very difficult for me to do my job effectively	1.64%	15.91%	26.42%	35.10%	20.93%	3.58
Generally speaking, non clinical managers have too much influence over service delivery in my hospital	1.35%	12.63%	22.37%	35.39%	28.25%	3.77
Generally speaking, non clinical managers have a good enough understanding of my work to exercise their responsibilities effectively	20.35%	41.37%	22.76%	14.56%	0.96%	2.34
I have respect for most non-clinical managers in this Board	6.94%	16.68%	36.84%	36.07%	3.28%	3.12

Generally speaking, non-clinical managers are trying to do a difficult job in difficult circumstances	1.93%	5.79%	19.96%	61.81%	10.51%	3.73
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These statistics reflected the majority views of managerialism expressed by our interviewees. So, not surprisingly, our interview analysis showed that criticisms of increased managerialism featured second after bureaucracy, as measured by a frequency count of qualitative comments.

A dominant theme emerging from the interviews was the zero-sum nature of changes in the balance of power between non-clinical managers and consultants:

*The balance of power sits very firmly I would say in the managerial court and that has increased more over these last ten years, the balance of power sits in terms of the organization it would seem the chief executive, the general manager and the finance director (Physician).*

*...The power definitely sits with managers. Previously when I started we were well supported and we were pretty much left to manage ourselves, and I think we achieved that fairly well to a fairly high standard. Now things happen without consultation and we find out about decisions by the back door (Surgeon).*

Non-clinical managers were also held to be responsible for the implementation of externally imposed service delivery outcomes, which were seen to conflict with consultants' patient care imperatives:

*In my work I treat both lung cancer and lymphoma, some of my lymphoma patients have slow growing lymphomas for which a realistic treatment option is to do nothing because the lymphoma may not trouble them for years and we will wait years before we actually start them on treatment whereas now we are under a pressure to start treatment within thirty days because that is the waiting time target and then we are looking at a situation where my follicular lymphoma patient who could quite happily wait five years before they get treated is accorded the same priority as my lung cancer patient who could be dead within thirty days if they don't start treatment really fast indeed ...I think it's the lack of clinical insight referring to non-clinical managers) and the crudity of these targets that are imposed that frustrates us as clinicians (Oncologist).*

*...I actually believe there is scope for getting more for the taxpayer's pound than we currently achieve...Waiting for a short time for an accurate diagnosis or exclusion of a serious condition is a good thing. Does it really matter that much if an elective non-urgent case waits a few weeks longer for treatment? NOT weeks NOT months, I'm not seeking a reversal of waiting time targets...(Free text response)*

The rationale of medical professionalism and patient care were also seen to conflict with the business-like healthcare and political logics, as illustrated in the next three quotations:

*It's a good political tool to persuade people the health service is improving because the waiting lists were too long before, but the trouble is, the way it was done introduced very quickly, huge amounts of public money spent on getting the waiting list down initially without any thought to the quality of the work that was being done and a lot of that work was having to be redone ...people coming back with complications ... so I think the way it was implemented was entirely wrong. ... ill-considered really because they didn't realise the knock on effects the... that waiting list targets are having ... on lack of continuity of care (Surgeon).*

*I'm not sure what the actual percentages are but I think the last time I read it was over a thousand % increase in the number of kind of senior managers in the NHS compared to twenty years previously and I can see why that is in that the culture of the service has changed in terms of how they deliver on waiting time targets, how they measure things, how they need to be reporting on kind of management performance in a way that probably wasn't true twenty years ago but I think that there is probably a huge amount of redundancy in terms of the amount of managers there are with time that is not used effectively in terms of improving patient service, improving patient outcomes (Physician).*

*Since I started as a doctor 27 years ago, I have seen an enormous expansion in non-clinical workers in the NHS, many of whom add little or nothing to patient care but count things for political reasons. There seem to be a great number of people who could not do my job but feel qualified to tell me how to do my job. I have also found HR management to be lacking in respect for the roles and responsibilities of consultants (Free text response).*

At the same time, consultants also pointed to the impact these changes had on their ability to control their working lives:

*Oh it's definitely decreased without a doubt it's decreased you know I think most people are saying the same thing, all of the responsibility with none of the power, none of the influence ... we tend to have these kind of consultation exercises designed and manipulated to come to the conclusion that*

*management want rather than anything else if I'm honest ...you know lots of input and discussion from people who have little actual...yes we all have to work together and psychiatry's very inclusive but these things often have major impact on how consultants work and yet the process is driven as much by allied professionals, psychology, occupational therapy, you know as much as it is by medics (Psychiatrist).*

Some consultants found it difficult to distinguish between non-clinical and clinical managers, a finding that we also take up in the next section on new medical elites:

*I think it's fair to say that that's the most frustrating aspect of my working life.... I think the power relations have changed very much in favour of those who are in management roles whether they be clinical managers or non-clinical compared to the power and authority that I have. And that came loud and clear in a very sort of in your face way when I stopped by mutual consent being the leader of (xyz) project ... all the agreements that we made were either slow in coming or changed direction and I wasn't comfortable with the way I was treated in that, I felt I was being forced in a direction other than what we had honoured to do and I felt that was really quite difficult and it was very stressful actually I didn't feel I had the power to carry on in that direction (Physician).*

There were also a minority of consultants who attributed non-clinical managers with sufficient power to place them on the 'back foot' or reduce them to the level of a 'technician':

*(Interviewee talking about non-clinical managers power)...they will come up with solutions and ideas that are so prejudiced against that, that before you even know it when you are trying to have a discussion, you're in a position of defence, you're on the back foot so you come across as defensive, you get then labelled as old-fashioned, hospital wedded, defensive, unwilling to change your practice, all these labels when you're just trying to defend what you know is right for the patients ...the health board is complacent and ignorant and neglectful and sloppy and actually atrocious in projecting the bed numbers (Psychiatrist).*

*I think if people actually, if people/management I guess to give them an amorphous name, actually talked to us, found out what it is we actually do, how we actually spend our time and what our areas of expertise are, respected those and helped us use them and allowed us the time and space to use them instead of side-tracking us ... you know it often feels like you're a technician - you know you're viewed as a technician (Psychiatrist).*

Criticisms often focused on the lack of non-clinical managers' insights into consultants' jobs and their apparent unwillingness to become involved in understanding patient care issues as defined by consultants. Only 16% of survey respondents thought that non-clinical managers had a sufficiently good understanding of consultants' work to exercise their responsibilities effectively, as illustrated in the next two quotes:

*What has disappointed me about management, particularly in (region), is the lack of imagination, lack of experience of the world, of life really, and failure to see the big picture and to see...fundamental values (Psychiatrist).*

*Management is more worried about the integration of the social work people than it is about giving power to doctors (Free text response).*

A minority of consultants questioned the qualifications and competence of non-clinical managers to influence clinical practice in the ways they did:

*The NHS now tends to be run by managers unqualified for the job or not qualified at all (Free text response).*

*I find that a lot of managers are kind of rubbish; they are there but I have not seen anybody come in to ask frontline clinicians OK what are you doing and what are the kind of, is there something that we can do to make things different (Psychiatrist).*

Managers were also seen to be 'hiding' from doctors, especially in large hospitals. Many consultants said that they had never met their managers who, they believed, deliberately avoided coming to wards for fear of being challenged with 'real life' problems:

*Managers never come to the clinics. They don't seem to have a very strong hold on what happens in the clinical areas so when there are things that need changing they rely on the clinicians to do it. So it strikes me that we're doing the managing thinking and the clinical work and yet we have got this huge hierarchy of managers gathering information and processing files and stuff reporting to politicians who can then make policies that are out of touch with what's happening on the shop floor as well. So I think there are too many managers, too much bureaucracy (Surgeon).*

An exchange between the interviewer and a senior surgeon produced yet another perspective on managers as being detached from action:



Surgeon *"How can we be better? What can we do to improve the situation?" They didn't ask any of those questions, they basically put it back to us: "What do we need to change in the (Board), to have a better dialogue of health care issues"?.... It came down to people saying, "Well, we need to have meetings and work time outs because meeting out of hours is bad for health and work life balance", or something crazy. So, we had all these issues which really didn't address the fundamental problem which is that managers are seen as, sort of, a... in a little fortress, they don't really want to come out of that fortress and meet the peasants.*

Interviewer: *So you think it's almost deliberate inaction?*

Surgeon: *Yes, I think so. I think, you know, it is, and I know it is the management by doing nothing, it's a management ploy. It's not... but it's not a good long-term management strategy at all. We're fine for the short term. I think that's half the problem about managerial culture in the same way that management in the industry is increasingly on a fast turnover and you're not responsible for the mistakes you made previously and your mistakes live after you but you've disappeared.*

Despite the mainly negative views concerning the role and increased influence of non-clinical managers, somewhat ambivalently, the survey data also pointed to 72% of consultants agreeing that non-clinical managers were trying to do a difficult job in difficult circumstances. The following quotations provide some insight into this apparently contradictory finding, which suggests that consultants saw managers as being caught in between the "rock" of political demands and politicians' promises to electorates, and the "hard place" of less resources on the ground to meet such demands and promises:

*Managers are not inherently distrustful or evil people out to do the harm to us I think they must also be getting out of bed in the morning to do the best of their abilities but I think they are simply being overwhelmed (Psychiatrist).*

*Yes I think to be fair the managers that I've come across I haven't really had direct liaison with them in that I've not been admin-lead and we tend to try and have a structure whereby we have an admin person or a lead person that liaises directly with our managers both in (board name) and here and they're different people so we try and structure our discussions through one person and a link with management and the managers have changed over time that's another thing there's a turnover in management so I think in general I have found managers to be good at listening to what we're saying but not necessarily being able to affect change as I would hope clinically (Physician).*

*I think they've (non-clinical managers) got an awful job and I think the first thing is that they've got everyone wants to be the visionary and nobody wants to deal with the hard facts on the ground, nobody wants to be the shop-floor manager that actually has no machines and can't do everything, everybody wants to sit on a Board Strategy Meeting and redesign things and they're the people that have to deal with those things and what happens is politicians come along and say we need this sorted and you need to save fifty million quid and they have to deal with that and what happens is there's lots of things that kind of you will see that it's just fire-fighting and prioritising and some of them are very good people (Physician).*

*It's a difficult question (on the role of non-clinical managers) because I think in a way the fault does not lie entirely with the managers. I think the managers are answerable to the politicians who govern the country and the politicians set the agenda in response to what they perceive as the population's concerns because it's the voting electorate. So if politicians think that what people are most concerned with is what is the waiting time to get your treatment that is what they'll set as a target and the managers not surprisingly then if their jobs depend on it will deliver to that target so they become focused on targets that are not meaningful in terms of clinical outcomes (Surgeon).*

*The health board regularly introduces unproven measures which harm patients. It's not their fault, the agenda is set by the Daily Mail and scared politicians. My job is to protect the patients from dreadful board policies but this is increasingly difficult. The health board is too big and does not allow doctors and nurses to run their services. Recent lethal examples include sepsis 6, which has no evidence of efficacy and will probably kill people through overtreatment (Physician).*

In line with our expectations, the survey data showed that those consultants with experience of clinical leadership/ medical management positions had a significantly greater acceptance of the hybrid nature of the NHS in which the balance between financial and medical logics in governing decision-making was appropriate ( $P < 0.01$ ). Moreover, some of consultants' experience of their relationship with non-clinical managers was positive, which was more noticeable in smaller and rural hospitals.

*I'm not in the least bit anti-manager I mean a lot of doctors they're anti-manager I mean I've worked as a manager as I said earlier on in my career and I think like a lot of certainly young doctors and I don't know if more senior people share that view I think some of them do but you thought that nobody has it as hard as doctors and that managers have it easy and when you go into that you realise well actually it's just the stresses are different but they are just there in just exactly the same way and the idea that an*

*organisation as big and as complex as the NHS shouldn't be managed is just ludicrous really so we need to have them...(Psychiatrist).*

*(Name) is our own hospital manager. We work very closely with her, she's been a tremendous, a lot of the changes are from her. Because we're small we do see a fair bit of our other managers.... Now (name), our chief executive, I'm you know, if I was in (major urban hospital in region), I wouldn't know who it was. (CEO name) you know comes down here, visits, has a coffee and has a chat and things. (CEO name) has been massively supportive (Surgeon).*

*This is quite a small place so you don't really have that pure sort of you know command that rarely works. We've had one chief executive who probably did offer instruction and was difficult to challenge but by and large managers I think you know like self-interest would get on with people so it would be quite unusual for you to be told to do something you didn't want to do that's you know there's plenty of negotiation...I kind of do trust the managers here because I think they are, they're pretty much all, they're all good people I don't think anyone's on any kind of hidden agenda power trip really I don't feel anyone's got any ill will at management level so I kind of, I do trust I've got a very good relationship with our general manager though you could argue that I probably cultivate that because it's a useful thing to have you don't really want to fall out with somebody or you know if you're seen as difficult you're not going to get you know what you want without a real struggle (Physician).*

## **INCREASING SELF-REGULATION AND THE CREATION OF NEW MEDICAL ELITES**

### **ELITE MEDICAL BODIES AND SELF-REGULATION**

The third strand of the thesis we examined was the impact of the growth in self-regulation through elite medical bodies such as the GMC and Medical Royal Colleges and the emergence of medically-qualified managers and clinical leaders. The survey data showed that self-regulation through elite medical bodies was a less important strand of deprofessionalization, although consultants tended to see the GMC and the processes of appraisal and revalidation as either insignificant or in a negative light (see Table 3). Thus only 28% of respondents to the survey agreed/strongly agreed that the GMC had been effective in self-regulation, while around two-thirds agreed that the GMC had introduced unnecessary levels of bureaucracy. However, in relation to both items, later-stage career consultants were significantly more likely ( $p < 0.01$ ) to hold negative attitudes towards the GMC, while those with experience in medical management were significantly more likely ( $p < 0.01$ ) to see the GMC in a positive light.

These attitudes towards the GMC were matched by attitudes towards appraisal and revalidation. Slightly less than 25% agreed/strongly agreed that appraisal was an effective development tool, only 29.8% agreed/strongly agreed that it was an effective revalidation tool, and only 30.3% agreed that revalidation was necessary to protect the public. Again, early-career consultants and those with experience of medical management were significantly more likely to have positive view of appraisal and revalidation.

**Table 3: Views on Elite Medical Bodies and Bureaucracy**

Survey items	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Mean
The GMC has been effective in exercising self-regulation of consultants	12.4	27.8	31.7	26.7	1.3	2.8
The GMC has introduced unnecessary levels of regulation to regulate the profession	1.7	10.4	22.2	35.9	29.8	3.8
The appraisal process for consultants is effective as a development tool	22.4	31.7	21.7	22.4	1.9	2.5
The appraisal process works well for the purposes of revalidation	17.4	21.0	31.8	27.7	2.1	2.8
Revalidation is necessary to protect the public	19.9	26.4	23.4	26.1	4.2	2.7

Interviewees' opinions were divided between those which pointed to the irrelevance of the GMC and colleges to their day-to-day lives, those who highlighted a significant but negative influence on consultants' work, and those who saw them as little more than a minor irritant in the system.

Two consultants, who captured the sentiments of many others, commented on the arguably unnecessary bureaucracy generated by the GMC:

*It doesn't really impact on your day-to-day work. It is a kind of background endless frustration of the utter waste of time of all the stuff from the GMC and the colleges you know revalidation, re-licensing, appraisal, mandatory training it's just utter nonsense and the amount of money that is spent on it in terms of the time ... you know the worst doctors*

*sail through appraisal because they know how to play the system (Physician).*

*I think medical bodies have actually made it a little bit worse for example adding on to appraisal and revalidation and things like that on an already busy and committed workforce without any thought for where is this time going to come from, what does the clinician have to give up to realistically engage with those processes because it is not a simple process, revalidation is a yearlong process (Psychiatrist).*

As illustrated in the excerpt above, appraisal and revalidation were a central concern of consultants. A view echoed in several of the interviews was that these processes may help to identify inept doctors but would not catch manipulative doctors because they knew how to 'play the system':

*The GMC, the one thing that's changed is with revalidation and reappraisal. So that's increased, you know, a lot of paperwork ... it's not – not that that's bad, I don't think. I mean we have to be able to show that we're operating as good Doctors. But, you know, a lot of these processes were put in place, after Harold Shipman. ... so they put in all of these safety checks, and appraisal, to try and pick out the failing Doctor. But if you ask me, Harold Shipman would have, um – would have, you know, managed to get through all the appraisal and revalidation, without any difficulty ... I mean, it might pick up someone who's got competence issues, generally, but not someone who's just out to do badness. (Surgeon)*

This next comment also emphasized the importance of ensuring that doctors were working appropriately, but also notes the potential flaws in the system and the challenges created by increased paperwork. The Shipman scandal appeared as a key driver of the reforms to appraisal and has led to a number of reactive changes, which, according to one consultant were a waste of resources:

*...The GMC I mean, I don't know, we seem to have gone after the Shipman thing into, we seem to have taken a giant step from some place that was very bad a doctor that killed his patients who was obviously a criminal and we seem to have used that as a springboard to do a whole lot of changes to do with revalidation and appraisal and so on ... we spend an awful lot of time on appraisal and wasted time on folders and stuff like that. I think the latest plans for revalidation seem to me to be a considerable step back away from the full on amount of things that we talked about a few years ago so*

*at least the GMC's seen that we cannot possibly spend all the time doing appraisals and revalidation, some of the time has to be spent working (Surgeon).*

The excerpt below makes three further points that arose during many interviews. The first relates to the positive aspects of appraisal in terms of setting development goals and engaging in regular training activities. The second highlights the relationship between appraisal and the increased bureaucracy of medicine and the shift in balance from clinical to bureaucratic activity. Finally, the third conveys the importance of negative press on public opinion of the NHS and how this press has contributed to a disempowerment of the medical profession:

*Well, I'm an appraiser. I've been one for five or six years now...I've never seen an appraisal where the personal development plan has actually been continued to fruition. Every single time, the same elements creep in, so I'm a little bit cynical about it. I think the reason it was introduced was to stop the Harold Shipman's of the world, again, but in reality, ... he was a one off psychopath hopefully and, you know, whatever system is being used, appraisals certainly won't stop another Harold Shipman. I think it's made people think a bit more carefully about making sure they take regular educational opportunities and record what they do a bit more carefully but it's increased the bureaucracy of medicine and it's made it less, um, easy to... you know, we spend a lot more time sifting through things for an appraisal and making sure we've got the stuff ready for an appraisal, which is... it's wasting clinical time in ways. I think there's probably better ways of doing it. ... I think it was introduced again to help with public opinion of the medical profession but, public opinion was actually damaged politically as well because I think the Shipman cases and the medical negligence cases that arose around that time as well were very, very well publicised. It was almost a political campaign to depower the medical profession so, you know, you're all terrible people and do everything wrong and you kill people all the time (Surgeon)*

These critical accounts, however, have to be balanced against others that interpreted appraisal as sound in theory but failing in practice. The excerpts from two interviews below note the value of appraisal but also raise concerns that in many cases it may become a 'box ticking' exercise.

*As an appraiser, I like to think that I add value but obviously you'd have to ask my appraisees. But certainly as an appraisee myself I have had appraisals that have been good and helpful and made me look at the world in a different way. I've had appraisals that have just been have you ticked all the boxes and that's not helpful particularly because that's just box*

*ticking. Nobody feels better for that. I've heard of spectacularly awful appraisals but I hope I haven't been involved in any that have been really negative (Surgeon),*

*I think with appraisal it's a good idea, I think it's a hammer to crack a walnut, a sledgehammer to crack a walnut and I think that for all the bad doctors there are, there are you know a thousand good doctors. I'm concerned that much of it is becoming tick box and it wasn't really to do with you know the good consultant and what they were doing but in general I don't have a problem with that I think that you've got to demonstrate your learning, it's appropriate for patient safety and I don't, I'm not concerned about that (Surgeon).*

The first quote draws attention to the context-specific nature of appraisal and the role that senior consultants and clinical leads play in the process. Supportive leaders who engage in constructive appraisal can encourage the individual being appraised to focus on their work activities and goals, demonstrate their learning, consider alternative points of view, identify and overcome existing challenges, and encourage better future performance. Linked to this, the second quote highlights the value of appraisal in terms of accountability and patient safety. However, both note that it can become a 'box ticking' exercise. The first relates this to poor leadership and poor implementation of the appraisal processes; whereas the second observes that the appraisal process is overly bureaucratic and not fit for purpose focusing more on key performance measures rather than individual development.

Despite the general criticism of the volume of time and effort required to successfully engage in appraisal, some consultants especially those with less than ten years' experience observed that it was just part of their job and not overly demanding:

*I'm lucky enough to be in the last group, so I'm not actually getting revalidated until 2016. But I have looked into the process and, to be honest – I mean, you hear a lot of moaning about it, but I don't think it's going to be that much extra hassle. There's, like, a patient questionnaire, and also a staff member questionnaire. It's pretty straightforward, I think (Physician).*

The statement above suggests that individuals who have been given more time to prepare for appraisal may be more receptive to the process. Others argued that the process was more time-consuming than it appeared on paper.

In addition to appraisal, a further theme to emerge from the interview data related to the political agendas of the medical bodies and colleges. For example, one surgeon observed how the GMC has contributed to a target or policing culture in the NHS, so ignoring the wider challenges of providing consistent and appropriate care:

*So there are things that are coming from the GMC that are in keeping with the political agenda and not necessarily focusing supporting doctors deliver policy and clinical care. So there's almost a sweeping under the carpet of the difficulties we face delivering consistent care. In preference to a huge big policing culture where the focus is more on what time you get to work than whether the patient that you looked after had the right care (Surgeon).*

Similarly, when discussing the Royal Colleges another consultant highlighted the political manoeuvring that could occur when colleges, motivated by self-serving interests, presented claimed 'half-truths':

*The colleges are organizations which are run primarily for the colleges themselves. I mean the job of the colleges is to perpetuate the colleges but they do have some very good meetings and most of what they say is true but they don't always tell you everything that there is to say and they don't represent the whole truth they only represent a fraction part of the truth (Physician).*

Others observed that the influence of the Colleges has reduced in recent years with training, guidance, and targets ultimately coming from government.

*The Colleges used to be, you know, lead a lot of the debate and lead our training, and such like. But, increasingly, they've been marginalised. So with, you know, training has now been politicised, essentially, because it went through the PMETB thing, and ... training is now under the auspice of the GMC, ultimately ... I mean – the GMC don't appear to have such direct, um, impact on things like, you know, waiting times, and stuff like that. It's all very political. ...I don't think they affect targets ... That's almost directly from government (Psychiatrist).*

### *NEW MEDICAL ELITES*

One important trend in the NHS has been the attempts to distribute leadership responsibilities to medical managers and clinical leaders, which somewhat ironically is



associated with the creation of new medical elites. This trend has been seen as a key attempt to bring about systems change by healthcare reformers such as Lord Darzi but has also attracted criticism in theory and in practice from many doctors, including some who have had experience of medical leadership (Martin et al, 2015). These criticisms were reflected in our survey (see Table 4), which showed that four of the six items we used to explore attitudes towards medical management loaded onto a more inclusive concept of deprofessionalization in our confirmatory factor analysis.

**Table 4: Views on Medical Management**

Survey Item	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Mean
We need more clinicians in senior leadership positions in this Board	0.5	2.7	20.0	52.0	24.9	4.0
I have respect for most medical managers in this Board	7.5	16.2	31.8	40.9	3.6	3.2
Medical managers in this board do an effective job of managing service delivery	8.6	25.6	34.0	30.2	1.6	2.9
Medical managers in this board do an effective job in representing the interests of consultants to senior management	18.9	31.2	28.5	19.6	1.8	2.5
Whenever clinicians take up a medical management position they seem to become a different person	1.4	15.1	34.2	38.1	11.2	3.4
Clinicians who go into medical management are frequently seen to have 'crossed a line in the sand'	1.7	21.1	41.1	29.2	6.9	3.2

76.9% of respondents' agreed/ strongly agreed that their health boards needed more clinicians in senior leadership positions; however, this high level of desire to see greater influence of clinicians in management was not matched by their experience of medical leaders. 44.5% of respondents' agreed/ strongly agreed that they had respect for most medical managers in their health boards, especially those with experience of medical

management, psychiatrists and physicians in women and children's medicine, and consultants with experience of other healthcare systems outside of Scotland. Yet, only 31.8% agreed/ strongly agreed that medical managers tended to do an effective job in improving service delivery, and only 21.4% agreed/ strongly agreed that they did an effective job of representing consultants' interests to senior managers. Again, as might be expected, these views were significantly more likely to be positive among those with experience of medical management ( $p < 0.01$ ).

To an extent, low levels of agreement that medical managers did an effective job could be explained by the identity changes that most consultants perceived to occur when doctors moved into medical management positions: 49.3% of respondents, agreed/ strongly that doctors became different people when going into medical managers, while 36% went so far as agreeing/ strongly agreeing that through such moves consultants had 'crossed a line in the sand'. These perceptions of identity changes were significantly more likely among mid-career and senior consultants ( $p < 0.01$ ) and some specialties, including anaesthesia, investigative medicine and surgery. However, while consultants with experience of medical management were significantly more likely to agree/ strongly agree the doctors going into medical management were to become different people ( $p < 0.01$ ), they were no more likely than others to agree/ strongly agree about doctors crossing a line in the sand.

Our interviews provided further insights in these survey data. Firstly, a consultant psychiatrist who was also a medical manager reflected on the potential for clinical leadership to be a positive force for reform:

*I think there's something about how the organization values doctors and something about the... the cultural stuff as well so I don't quite know where it sits but I think quite a lot of doctors... well, a lot of doctors, almost the majority experiencing this... burn out, stress, feelings of not being engaged with the bigger picture, not being able to influence and move things and I think there's an acknowledgement that senior managers ... have to accept that that is the case and that's currently happening and if they dealt with that in different ways, they were more engaging, more distributive, you know, as we discussed, more empowering, a) they'd get better doctors, b) the doctor would be happier and less stressed ...also we'd actually get a lot more use and utility out of the doctors to help with the management because the leadership and small management role of a consultant is crucial within a team, and that's very much a missed opportunity (Psychiatrist and Medical Manager).*

This view was supported by one surgeon, who believed that having consultants take up medical managers' roles could help restore doctors' professional identities and influence:

*I think the growth of clinical leadership roles is an excellent idea but they need to be encouraged not whipped, so we need to feel that there's value. Quite often there are opportunities for us to do things which we don't take up because the whole feeling is of we want to take a clinician on this committee because the committee is going to decide anyway rather than genuinely seeking our input. So, basically, re-empower doctors. I think doctors, unless all their professionalism has gone completely, want to be empowered to be professional, will give more than take, and be very valuable members of the team (Surgeon).*

However, this optimistic view expressed above regarding the potential for medical management to be a positive force for change was not supported by our interview data on the practice of medical management, respect for medical managers or the effectiveness of medical managers in managing the service. Indeed, the majority feeling among consultants, including some with experience of medical management, was that the wrong people frequently ended up in clinical leadership roles, that they did not represent consultants' interests and that they became different people when taking up such a role. The following quotes highlight specific dimensions of consultants' worries about medical management. The first of these points to the desire of many consultants to see more doctors in medical management, but highlights the problems in practice and the need to provide early training and development:

*I think getting more consultants into clinical leadership roles is going in the right direction, but more thought has to be given to getting the right or best ones in post and also getting people at the right time. I mean I have seen people step over the line and take on managerial roles as they near retirement as a step on the way out which isn't great as you lose the benefit if the clinician no longer carries their clinical role. On the other side, I have seen individuals take on a managerial role without additional support for their clinical role, which tacitly means they are giving their colleagues additional work. ... It may not be perfect but it does begin to break down some of the barriers in communication and at least they understand the clinical side of things. ... I think building in training when doctors are in their 30s (mid-career) would be beneficial. This would mean that they can develop these skills over time before having to deal with the pressures of a dual role (Surgeon).*

The above excerpt makes a number of insightful observations, including the need for clinical leadership roles to be adequately resourced to ensure that the clinical team works effectively and that leadership skills take time to develop. Moreover, it reflected a view that some clinicians see those taking up managerial roles as a step towards retirement and being out of touch with their clinical specialty. The next series of quotes highlight different types of scepticism concerning individuals who apply to go into medical management roles:

*I think certain clinicians should go into leadership but not necessarily the clinicians that apply for the leadership roles. ... I worked in places... ...both in Europe and in China, the senior consultants are doing less and less clinical work and more and more managerial work because they've got the experience. Some of them actually quite like doing that and at the moment, we've got a culture which tends to allow younger clinicians to be managers because they have an interest in it and maybe twenty years ago, I might have been that clinician so maybe I'm going against myself but I think the trouble is, it does encourage people who see it as a quick way to power and to, shall we say, self interest, and perhaps because they don't actually like their clinical jobs, you know, for the reason that they can't do it (Surgeon).*

The statement above suggests that some consultants believed that medical management roles often attract individuals with a strong desire for power rather than consultants with the best medical and leadership abilities. This somewhat negative view of consultants who enter into management roles also extended to a perception that medical management attracted clinicians who were target rather than patient driven:

*I think that's true (in response to a question on the need for certain traits necessary for clinical leadership) and I think you know that they are, you know, as I say bridging that divide in a way is that it's not two different tribes in that you do have clinicians who become managers and the interesting thing I think is that those clinicians who do become managers are selected for the personality traits and for the ambition that aligns itself with what the management perceived essential specifications are for the job. So if you know they advertise for a lead for one clinical area within the service we as the clinicians in the service know that the person who has applied for that job is perhaps the least appropriate person to be managing the service but they are the most likely person to get the job because they will fit in with what the specification is as perceived by the management because they are people who are driven to deliver on management targets and they are people who are divorced and in many cases alienated from colleagues before they even get that job (Anaesthetist).*

Further scepticism was expressed concerning doctors who adopted a managerial rather than clinical agenda when taking up managerial roles:

*I'm very sceptical of doctors that choose to become managers because they choose to become managers in order to succeed in management they have to follow the management agenda otherwise they will not succeed in the management circle and to the extent that they succeed in the management then I'm very sceptical about following those people as leaders, I'm not saying that I wouldn't ever do what they say but what I'm saying is I would keep my own counsel ... if I have a leader I like to be able to know that I trust the leader to make decisions that I don't know the ins and outs of whereas with my medical colleagues who go into management I'm not sure that I do trust them to make decisions that I would approve of if I knew the ins and outs of it and that means that they're not really trusted leaders to me (Radiologist).*

Finally, consultants, especially more senior ones who had not pursued clinical leadership roles, questioned the integrity of doctors who sought clinical leadership roles, sometimes suggesting they had gone over to the “dark side”, seeking personal gain and rewards:

*There's a suspicion amongst some of us (particularly younger) consultants that some of the senior medical hierarchy will go with the flow or with the policy because they will be rewarded later on. At a local level this can be with discretionary points or awards but you see it even at high levels. Many doctors who help a government report will get an OBE, or if you sit on a certain committee and support government policy you'll get a knighthood. As a result I think many younger consultants feel their medical leaders and bosses do not represent them. They get so high up in the system that rewards them that they become part of the management system rather than representing doctors. There are even some joke terms for this; 'Gongitis', 'knight' fever and 'lorditis' (a reference to Lord Darzi). For some people it seems to become very seductive - working for managers, the government or within 'corridors of power'. They seem to enjoy this more than clinical work with colleagues. They are seen as having 'gone native'. ... It's another part of the 'network' that operates with the medical profession. If you're not part of it, you don't get promoted or rewarded. Only those who are prepared to toe the line are appointed and rewarded (Physician).*

An exchange between one of the interviewers and a radiologist raised further questions over the motives and identification of medical managers, especially medical managers located off-site:

*There's medical ones and... and I don't have a problem with all of them because a lot of them are colleagues, people I trust, people who are reasonable to work with, um, so even within my line management... I'm not saying that I suspect everybody above me, but some of my managers at (teaching hospital headquarters), you don't think of them as managers. That's the difference. Medics have traditionally had a, kind of, hierarchical structure but you've never thought of the guy above you as your manager, ...they're just taking the responsibility for a while and they step back down again. That's also what's happened, so I don't think of medical managers in the same way until they get very high (Radiologist).*

*Interviewer: Until they get very high and what happens to them, do you think?*

*And then the management chip gets implanted in them and they forget about being a doctor... associate medical director and up... they then cease to be like doctors and then become part of management.*

In line with the views of some consultants on non-clinical managers, other interviewees attempted to rationalize the position of medical managers as being caught up in a system in which they had no option but to focus on external targets and the effect of these targets on the performance of consultants:

*I feel that medical managers are constrained by political targets and meeting these with limited resources is undoubtedly difficult. They tend to isolate themselves, often geographically, from the clinical realities - a fuller appreciation of these would make their decisions more uncomfortable. The clinician is left to get on with working around the ever-increasing obstacles to providing good quality patient care (Free text comment).*

As the survey data highlight, consultants in medical management positions tended to see things differently, as illustrated by the three free text quotes below. All three quotes point to the problems medical managers have in engaging with consultants and what is sometimes perceived as the lack of awareness of consultants about the hybrid nature of healthcare.

*My eyes have been opened by what I've seen in medical management: huge efforts to engage with consultants and appalling behaviour by doctors (Free text comment).*

*Clinicians need to be given control over financial decisions for their team, but also the responsibility for delivery. Only then will clinicians face up to*

*tough decisions and make them in patients' interests (Free text comment).*

*Managers are an easy target for doctors as they have responsibility for implementing difficult financial and political decisions. I have always found working with them more productive than attacking and undermining them as some colleagues seem to prefer. If we wish to be listened to and earn respect from colleagues, clinical and non-clinical, we need to behave the same way towards them. With more than thirty years in the NHS I enjoy my work as much as ever and feel that working in medical management allows me to influence change positively for the benefit of patients. Some of my colleagues expect that I should act as an advocate for doctors exclusively but as a manager it is the public, patient safety and the service that supports patients, which must be the priority (Free text comment).*

However, even among consultants with experience of medical management, there was a feeling that they should be doing more to challenge the system of control:

*I have sympathy for the difficulties of medical management. I do not have sympathy for the lack of courage of both medical and non-clinical managers in standing up to unachievable tasks and targets. As a clinician I have to stand up to the clinical challenges that confront me. Oh if that was the case in management. My experience of medical and non-clinical management is one of repeated half and complete untruths with a disregard into patient care until their job is on the line and they then run for cover (Physician).*

Medical managers also spoke of the stress they faced from increased demands on their time and lack of resources:

*I have been employed as a Consultant since 2001 ...inevitably I have become more involved in the management of a department ... Thus, I have become more involved in job planning, service redesign, appraisal etc. I find it very time consuming but have a good relationship with my Associate Medical Director and less contact with more senior (non-clinical) management. ... I feel that I now have a greater understanding of the pressures, need to improve inefficiency in service etc. I find being a Lead very stressful and personally challenging. (Free text comment)*

*Many of my answers are coloured by my experience of medical management over the past 3-4 years, which has been extraordinarily bad.... I have felt disillusioned, disempowered and not listened to when trying (with colleagues) to raise concerns about patient and staff well being. How disappointing to work for an organization that is supposed to care for folk who don't even listen, far less believe folk at the front line... (Free text comment).*

## THE PROLETARIANIZATION THESIS

As explained in the literature review, proletarianization refers to feelings among doctors that their jobs are being de-skilled and routinized. Linked to deskilling are perceptions among doctors that their traditional status as autonomous professionals and the trappings of status are diminishing to the extent that they see themselves as being treated as ordinary employees, subject to a wage-work bargain. In turn, they are more likely to be willing to join associations to pursue their collective interests and to take interests action to pursue collective interests.

In our survey, we included four items to address the extent of feelings of proletarianization, one concerning lack of job challenge, two concerning perceptions of attempts to reduce consultants' status through dress codes and office accommodation, and a further one on the greater willingness of consultants to take collective action. Factor analysis confirmed these as separate dimensions of proletarianization.

Our survey data point to the following conclusions on proletarianization. The first is that it consultants across the board reject the perception that their jobs have become less challenging, with only 9% agreeing/strongly agreeing with this statement. Second, 30.8% of consultants' agree/strongly agreed that their role had been diminished by unnecessary dress codes. This was significantly more likely to be expressed by surgeons and anaesthetists, and significantly less likely by psychiatrists ( $p < 0.01$ ). Moreover, 39.5% agreed/strongly agreed that their jobs had been made more difficult because of the allocated office accommodation. Third, 56.3% agreed/ strongly agreed that since becoming a consultant they were more willing to take collective action to gain a voice in matters that affected them, with early career consultants significantly more likely to agree with this statement ( $p < 0.01$ ).

Our qualitative data provide a more nuanced perspective on proletarianization. During the interviews it was noted that continual advancements in medicine together with the consultant's own personal drive for development meant that the clinical aspects of their work remained challenging and rewarding. However, increased demand, meetings and repetitive bureaucratic paperwork were creating additional and unwelcome pressures. One surgeon captured the balance that has to be made:

*There is more bureaucracy, more admin, paperwork and meetings and these can take over, but I am getting better at managing these and keeping meetings to time ... In terms of the clinical aspects, it gets easier to do the operations but I wouldn't say it gets routinized. I am still getting better at my specialism and I get real satisfaction from doing it well. Every day/week brings something new which keeps it interesting (Surgeon).*



A further theme that emerged in many of the interviews was the sense that changes brought about by the variable implementation of the 2004 Consultant Contract, which we take up later in this document, together with the legislation introduced by the European Working Time Directive, had led to a culture of 'clock watching' and 'working nine to five'. The excerpt below highlights the feelings expressed by a high proportion of the consultants that they had lost control over aspects of the delivery of clinical care including responsibility of their own patient lists. Some interviewees suggested that selection was now target based and secretaries without a full understanding of specific cases were allocating slots by 'picking a card with a name on it'. It was further suggested that this created issues both in terms of efficiency and continuity of care and was a source of great frustration for consultants:

*If we're sued, it's us that get sued not the managers. If we get disciplined by the GMC it's us that get disciplined rather than the managers. And yet my ability to control the delivery of clinical care is getting less and less and less. So I've got all of the punishments and none of the power. And doctors are people who are used to responsibility. When they select people for medical school they put a lot of emphasis on having taken or shown leadership roles in schools or in life before medicine. So you are picking out a group of people who are used to or comfortable with bearing responsibility or taking leadership roles. And you are turning them into standing in a corner and behaving themselves. And for that group of people it just makes them frustrated... They're doing their nine to five and then going home. And medicine never used to be like that (Surgeon).*

The excerpt above highlights the frustration that the consultants felt at having aspects of their professional autonomy removed. It suggests that medicine attracts individuals who are comfortable with responsibility and taking the lead but that new procedures had forced them to fall in line. Moreover, the interviewee observed that doctors were still frustrated since they remained responsible for care outcomes but had only limited power to influence the delivery of care. Such a view was graphically illustrated in the following free text comment:

*I have been a consultant for 19 years. During that time I have seen management expand through self-perpetuating bureaucracy while the position and role of the consultant has been diminished by underfunding, inappropriate policies and ridiculous diktat. The role of the consultant is clearly viewed by management to provide patient care on a shoestring and to do so unsupported and to take the blame when patient care goes wrong even if the cause is faulty management. There is little acceptance of clinical governance. Repeated policies clearly want our skills at a cut-down price while the rewards for excellent service go elsewhere. This attitude has been reinforced by the supine acquiescence of the GMC and the Royal Colleges to every proposed change. In a few years consultants will have taken over the*

*role of every junior doctor even to the extent of living in on call (without pay) and will be viewed by management as a health care "production line worker" to be treated as they feel disposed depending on that week's initiative. This is not good for anyone.*

Some interviewees also commented extensively on the symbolic attempts to decrease the status of the consultant through, for example, the changing dress code – i.e. the removal of white coats, and limitations of what doctors could wear when in hospital. Others also commented on the move away from individual offices, which they felt impacted negatively on working conditions, and the reduction of communal spaces that hinders communication between doctors. One good example of this loss of symbolic status resulting from material changes in their working environment is this quote:

*I am no longer an important person, someone whose views are listened to. I am a hospital technician, whose daily life is dictated by someone with no medical training whatsoever. I now share 'my' office with two others, and 'my' secretary with three others (Free text comment).*

In a similar vein, the following quotation from one of the interviewees highlights the challenges that can occur due to poor logistics and a lack of basic amenities such as having a computer and telephone that functioned properly:

*I have an office on the twelfth floor. My Secretary is on the fourth floor and I don't have a phone that works in my office and my computer doesn't work ... so I spend a lot of my time, 'admining', standing beside my Secretary's desk ... it just does not help, you know, how efficiently you can work... and it gets frustrating. You see, you know, some of the management offices, some of the Nursing Managers ... they've got an office to themselves, a nice big desk, and stuff. And I've got three colleagues sharing the same office. And again, it just comes down, a wee bit, to this erosion of clinical respect (Physician).*

As evident from the quote above, there was a perception that office sharing and poor office space design was part of a wider agenda to erode doctors' traditional status. The removal of communal spaces for doctors and other clinicians appears to have decreased their morale and their sense of being part of a community of practice:

*The other thing that I think management or a lot of hospitals have done is they've broken staff morale by not having common tea rooms. I mean people used to have a common room and you would get to know your colleagues (Physician).*

*Yes, exactly just a doctors' mess ... and then you get to know people that would improve the work experience I think. The other thing is I think better sort of integration and communication with management. I really to be honest don't know what they do. ... I think perhaps better sort of, knowing the structure, knowing where the line management lies in a lot of wards and a lot of places it fluctuates so much (Radiologist).*

*I think we do miss... and it's not just the socialising and being together, when I think back to ... when I was a junior doctor, how much business was done in the doctors dining room at lunchtime with people just saying,, "Can I talk to you about so and so?" or, "What do you think? What would you do about this", you know, lots... lots of learning went on over the table, lots of advice freely given and shared but also ... we've lost the actual caring for the juniors in particular, I think, because when I was a junior, if I didn't turn up for my lunch, lunch would be left for me in the warming tray because they would know that, you know, you haven't been, you must be busy, you'll be along later and there'd be food there and it'd be reasonably fresh but none of that ever happens. Whereas now, at night, ... if the canteens shut, the canteens shut and you're basically on your own finding a takeaway or getting something out of a vending machine and that's... that's not good (Physician).*

The lack of private spaces, away from patients and relatives, was identified as one of the causes of poor team working and cross-specialist knowledge exchange because consultants had lost an opportunity to discuss patient cases in informal settings. The second quote above also illustrates a need for better communication by management explaining why decisions are being made.

A further theme within the proletarianization literature is that as professions lose status they are more likely to engage in collective action. Amongst the consultants interviewed there was little appetite for formal strike action but several participants noted that coming together with colleagues was a central element in overcoming the pressures of the job. Collaboration was a means of gaining greater collective power to oppose, as they saw it, an increasingly managerialist agenda, illustrated by the following quotation:

*I think the main way of coping is by talking to colleagues and seeing that you are not alone and that others are facing similar pressures ...I think what would really help is if we could get back to better teamwork but that is never going to happen in the same way as it has in the past with the new range of junior doctors and registrars shifts and the various flexible working patterns of consultants within the team... we still have some autonomy and if clinicians or consultants come together and disagree with a decision or initiative because we think it is just for 'management sake' then we can do something about it (Surgeon).*

Despite views on the value of collaboration, other interviewees saw consultants as typically individualistic. Two explanations were given for individualism among consultants: (1) the individualistic personality characteristics of those attracted to medicine, which made them more susceptible to (2) a political desire to 'divide and conquer' professionals and specialist on key issues to reduce their overall power to oppose change. This perspective is summarised in the following reflection:

*I don't know why clinicians don't work together. Clinicians seem to be quite individualistic people, which is just possibly part of the clinician personality and they seem to be very bad at uniting and speaking with one voice and that's not good. Because the divide and rule principle is then very easily implemented - I think there's very active policy on the part of the governments of both England and Scotland to divide and rule ...the current policy is to break the power of doctors. So my impression is that ... doctors are not good at unifying and protecting our camp (Surgeon).*

### *LOGICS GOVERNING DECISION-MAKING*

So was there an underlying factor that helped explain the above findings? In our framing of the research we proposed that a business-related logic (bureaucracy and managerialism) and a political logic would be seen by many consultants to govern decision-making on the organization and management of healthcare in Scotland. This was indeed the case: our interviewees and survey respondents overwhelmingly saw business-related and financial rationales governing decision-making in their Boards rather than medical professional judgements. The survey results showed 73.3% of consultants' agreed/strongly agreed that business and finance-related judgements governed most decision-making in their Boards, while only 14.85 agreed/strongly agreed that medical professional judgements governed decision-making in their boards. This perception of a dominant business and financial logic was further evidenced by responses to a question concerning a balance between the two; only 17.7 thought that there was such an appropriate balance between business and financial rationales and medical professional rationales in the governance of decisions in their Boards. Interestingly, these findings did not differ significantly by demographic grouping.

The interview accounts provided many illustrations of how consultants viewed the changed nature of decision-making rationales in their Boards, exemplified by the following quote that contrasted previous decision-making with the business-related rationale that was seen to drive investment decisions:

*I managed to persuade the Health Board to give us a new (name) Centre, which took a lot of work. But we worked with them and, you know, financially it was going to cost serious money but we found a way around that to present to the Board and things like that. I'm not sure that could be done that way nowadays. ...I think everything is driven financially and it's put above everything else really because we've had cut after cut...I mean I don't relish the job the Health Board is having to do, I mean, they have to account for every penny spent...And, it's...become a lot more difficult for them. (Physician)*

The physician quoted above recognised the pressures that non-clinical managers faced. Much more common, however, was a view among consultants of managers making decisions on organizing healthcare services according to a business-related logic almost regardless of the consequences for medical judgement and sometimes without appropriate consultation:

*So the bed pressures are building up. And management make a decision...that consultants should be doing more ward rounds at the expense of specialty work, which I think is an appalling decision to make. And I learned about this by email, it just said 'by agreement' - who agreed to this? ...So you've got all these consultants trained in their specialty medicine, but now spending three mornings or three half days a week just on, well, long ward rounds. You're seeing sometimes chronically old patients, you know, that don't necessarily need to be seen every day by a consultant, I mean a doctor, but not a consultant (Physician).*

The impact of business-related rationale was most notably felt in relation to target setting and waiting times, as demonstrated by this next account:

*It's a good political tool to persuade people the health service is improving because the waiting lists were too long before, um, but the trouble is, the way it was done introduced very quickly, um, huge amounts of public money spent on getting the waiting list down initially without any thought*

*to the quality of the work that was being done and a lot of that work was having to be redone, you know, this waiting list initiative work in, people coming back with complications and, um, having had the treatment done elsewhere, um, and it... you don't need to be treated in eighteen weeks for a condition you've had for ten years. ... I think the implementation was far too fast but far too ill considered really because they didn't realise the knock on effects ... on lack of continuity of care (Surgeon).*

A political rationale for decision-making also came through strongly, especially in the reflective free text responses. These were sometimes seen as alternative explanation to the centrality of a business-related logic. The following two quotes illustrate this point well:

*I feel that medical managers are constrained by political targets and meeting these with limited resources is undoubtedly difficult. They tend to isolate themselves, often geographically, from the clinical realities - a fuller appreciation of these would make their decisions more uncomfortable. The clinician is left to get on with working around the ever-increasing obstacles to providing good quality patient care.... My clinical work is profoundly rewarding but the system in which I work, as compared with even 10 years ago, ever impedes me rather than freeing or trusting me to deliver the professional service which I regard as a vocation (Free text response).*

*Financial constraints are always in evidence. Management is reduced to fire-fighting - long-term solutions are extremely rare. Scottish Government strategy of offering a poorer Consultant contract in Scotland compared to the rest of the UK over several years has been very short-sighted and is causing increasing problems in recruitment - especially outside the central belt. Too little emphasis placed on seeing return patients with known pathology leading to clinic backlogs and patient harm (Free text response).*

Other consultants were more direct in their attributions in blaming a political logic and the generation of unrealistic expectations among the public as the root cause of systemic problems in NHS Scotland, as the following selection of free text comments illustrate:

*I think unrealistic targets set by governments in constrained financial circumstances has led to a shift towards employing more non-clinical staff to come up with ways of meeting targets rather than employing more clinical staff to treat patients in order of clinical priority. There is also a culture of raising unrealistic expectations for the public. In that sense although I sound critical of board managers I am sympathetic to their situation (Free text response).*

*The political agenda based on waiting times is an inappropriate way to assess healthcare. They have taken what is measurable and made it important instead of measuring what is important. Outcomes are all that matter to patients but the media and politicians have 'infantilised' our population by indoctrinating them about what issues are important in healthcare. Consultants have been debased to drones, driven by inappropriate targets, matched with insufficient resources, with the devaluing of time spent on anything other than measurable activity. Time as a clinical tool for patients has been sacrificed on the altar of waiting times (Free text response).*

*Too much political interference, particularly from (the Scottish Government) and civil service in NHS here. Us/them culture prevails here. Have been treated very badly and consequently will be moving to England to work, consultants views are not valued or respected in this HB (Free text response).*

*Health care in Scotland is led by people who are influenced by political self-interest. The targets are ridiculous GPs are being pushed to the brink therefore creating a tsunami of referrals to secondary care. There appears to be no political will to educate the people of Scotland in health related matters....The constant derision of doctors in the press seems to have given patients the attitude that nobody cares so they are rude and take no responsibility. Scottish patient safety has not led to a culture of free expression, there appears to be no concept at board level that a free and open culture is a good thing. Would I feel supported if I made a mistake -NO. The Francis enquiry has made little impact here managers appear arrogant and have no insight that they are creating the very climate where these mistakes took place. The Scottish Government appears to have created a bullying culture. Would I recommend colleagues to come to Scotland -NO (Free text response).*

*I have recently had thoughts of leaving the profession. The expectation of patients is overwhelming and encouraged by irresponsible politicians' soap-box promises (Free text response).*

*I think NHS Scotland is slowly emptying out of its medical staff. This is multifactorial and worsening. Mainly very poor pensions for younger doctors, an ageist merit awards system closed to younger doctors causing steady emptying of important senior roles, and working with a feeling that one is forced to focus on new patients - some of which have a significant health problem BUT one is unable to keep up with the bow wave of return patients, all of which are known to have a significant health problem. This is very demotivating and the government needs to allow us to prioritise care in the best way for healthcare not best for votes. Basically devolve the NHS away from the politicians.... (Free text response).*

*There is no political appetite to inform the public that health care rationing already exists in the NHS. The lack of money/resource within the NHS is now affecting patient care. There remains waste within the NHS but the*

*introduction/interference of politicians and probably bad advice from the advising clinicians to government ministers means that the cost of achieving healthcare and running hospitals has gone up because of the increase in the number of managerial staff required. Why are there policies within the NHS not to hold managers to account for poor performance? Why is the governance of managers so poor? That is, they never get sacked only moved to another managerial position.... (Free text response).*

## IMPACT ON TRUST RELATIONS

In the survey, we used a shortened, three-item scale for assessing trust in non-clinical managers, based on consultants' beliefs about non-clinical managers' competence, benevolence and integrity (Mayer et al, 1995). Confirmatory factor analysis showed that these three items were highly correlated with items concerning perceptions that a business-related logic determined decision-making in their Boards, consultants' lack of voice in decision-making, their negative attitudes to non-clinical and clinical management, and a lack of connection or engagement with their Boards.

The survey data show that overall level of trust in non-clinical managers, as measured by our three-item scale, was low but not significantly so (mean = 2.73), with little variation across demographic categories. Breaking this scale into its constituent parts, the lowest levels of trust were attributed to expectation that non-clinical managers would act benevolently in the best interests of consultants, with only 11.9% of consultants' agreeing/ strongly agreeing. Trust in their competence was also low, with only 24.7% agreeing/ strongly agreeing. However, consultants were more inclined to rate non-clinical managers as honest, with 29.3% agreeing/ strongly agreeing, with those with current or past experience of medical management significantly more likely to believe non-clinical managers to be honest ( $p < 0.01$ ).

**Table 5 Trust in the Organization and Senior Managers**

Survey Item	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Mean
Most non-clinical managers in this Board do a competent job	6.4	23.3	45.6	24.3	0.4	2.9



I feel that most non-clinical managers in this Board would act in my best interests	24.2	32.6	31.3	11.6	0.3	2.3
I would characterize most of the managers in this Board as honest in their dealings with consultants	8.3	23.2	39.4	28.4	0.9	2.9

Again the free text comments in particular were revealing in helping explain these survey data in a more nuanced way. Typically, they pointed to political and bureaucratic control, and the increased influence of a managerial agenda as the cause of a low trust dynamic, in which low trust initiatives set by politicians and managers was met by a low trust response from consultants:

*My clinical work is profoundly rewarding but the system, in which I work, as compared with even 10 years ago, ever impedes me rather than freeing or trusting me to deliver the professional service, which I regard as a vocation (Free text comment).*

*Any shine has come off long ago. I wish I could now do something else with what I've learnt. I don't trust senior management to do anything that doesn't improve the financial position. (Free text comment).*

As noted in the earlier sections, the consultants we interviewed were critical of “micro-management”, which, they believed, was an important source of a low trust dynamic in their hospitals:

*The goodwill, previously abundant in the NHS is constantly being eroded. I don't believe management had or have any idea how much work was being done and time spent on service improvement etc. The constant mistrust and micromanagement demonstrated over management of clinics / PA's / annual leave etc., is depressing. The feeling you get is that they believe we are constantly trying to get away with things (Free text comment).*

*I feel demeaned and disrespected by Scottish Government politicians and non-medical managers. There is no relationship between how hard I work or how well I perform including patient outcomes, and my income (Free text comment).*

Strong disappointment from being under-valued was also a feature of accounts by consultants during interviews and free text comments:

*Medicine continues to be a varied and stimulating profession but increasingly I feel undervalued by my employer. There is a prevailing "stick" approach with very few carrots and never a word of thanks from management and very few words of thanks from patients either, who assume they are getting a third rate service as this is what they are continually told by the press (Free text comment).*

Criticisms of the integrity of non-clinical managers were also common. There was a sense amongst many of the interviewees that managers sent out dishonest signals, by “pretending to listen” to doctors opinions and engage in “fake” consultation, while having little respect for clinicians’ views and by continuing to pursue political and managerial agendas:

*Management do not listen, try to avoid making decisions, are untrustworthy and give us no respect. I am hoping that our new CEO will make a difference, he seems to be trying (Free text comment).*

*Managers will hang you out to dry. If there is a problem, they kid on they listen but don't. (Free text comment).*

*The management feigns to listen to the clinicians and then goes ahead and does exactly what is dictated by its own agenda. There is an attempt to streamline whole systems but because managers do not respect clinicians, integrated lean and progressive service development remains a dream (Free text comment).*

*On a scale of one to ten, if one was 'I didn't trust them (managers) an inch', then probably about a three. And in terms of patients, on a scale of one to ten, probably about five. (Physician)*

*I have no confidence whatsoever that managers act in my best interests. I would say it's not completely zero but it's certainly not ten. So if my needs are not contrary to the management view they'll act in my interest. But they'll certainly not prioritise my view. (Surgeon).*

This last comment highlights how a lack of engagement with clinicians could have a detrimental impact on the success of initiatives especially those that require clinical collaboration and whole system thinking at all stages in the patient journey. Worryingly, a small group of participants went further and suggested that there was a “bullying culture” within NHS Scotland. Some felt trapped, and could not recommend their hospitals as enjoyable places to work:

*The Francis enquiry has made little impact here; managers appear arrogant and have no insight that they are creating the very climate where these mistakes took place ...a bullying culture (Free text comment).*

*I'm worn out overworked feel like I am being constantly watched and monitored. Can't wait to retire but feel trapped in Scotland now (Free text comment).*

However, other consultants suggested trust relations were personalised to specific managers, sometimes giving examples of previous good and bad practice:

*I think that's person specific, there are some that I trust and there are some that I wouldn't trust to cross the road without getting hit by a car. I think my job is to be the patients' advocate and the advocate for my staff. I think the manager's job is to work for the organisation and ultimately it's about money and they should have patient safety high up there but if they're non-clinical they maybe don't always understand clinical issues and that's why it's important there is good relationships so that they can keep you right on the things that they are good at and you can keep them right about the clinical side of things but it comes back to that partnership and if partnership works well it's a good team and if it doesn't work well you will always be clashing (Physician).*

## IMPACT ON DIFFERENT LEVELS OF ENGAGEMENT

As noted earlier, engagement is a management consultancy led term that has begun to gain currency among management and organizational studies scholars. Based on a previous review of the academic literature related to engagement, we chose to operationalize the concept in terms of four interrelated levels at which individuals can express cognitive and emotional attachment and behave in an engaged way. These levels are (1) engagement with their jobs (task engagement), (2) engagement with each other (relational coordination), (3) engagement with their employers, in this case their Boards (organizational identification) and, (4) engagement with the sector, in this case the NHS (field-level engagement). From our knowledge of the literature on deprofessionalization, the sociology of the professions and medical sociology, we expected to find from the survey results that consultants would be likely to:

1. express high levels of engagement with their jobs, based on our knowledge of the orientations to work of medical professionals,
2. express high levels of engagement with colleagues in clinical teams
3. express high levels of engagement with the NHS

We also expected to find a high degree of inter-correlation among these three levels of engagement. Finally, we expected to find consultants had lower levels of engagement with

their Boards because of the largely *cosmopolitan* orientations to work of consultants (who typically show a greater attachment to the profession than to any specific employer).

Our survey data strongly supported these expectations. 86.3% of consultants agreed/strongly agreed with the statement, 'I share the goals and values of the NHS', with the only significant difference being that surgeons were less likely to agree ( $p < 0.05$ ). This represented a mean score on the five-point Likert-scale of 4.21, the strongest level of agreement any item in the survey. The means for the other factors, in descending order were, job engagement (mean = 3.96), engagement with each other in clinical teams (mean = 3.94), and, much further behind, engagement with the organization (mean = 3.08), with consultants employed in larger boards and those without experience of medical management reporting significantly less engagement with their organizations ( $p < 0.01$ ).

**Table 6 Engagement with the job, each other, employers and the NHS**

Factor mean	Factor Item	Item Mean
Engagement with the NHS = 4.21	I share the goals and values of the NHS	4.21
Engagement with the job = 3.96	I feel happy when I'm absorbed in my work	3.97
	I find the work that I do full of meaning and purpose	3.75
	At my work I always persevere, even when things don't go well	4.23
	Being a consultant plays a big part in my sense of who I am	3.89
Engagement with each other = 3.94	People in my clinical team communicate accurately about important information	3.91
	People in my clinical team communicate frequently about important information	4.07
	People in my clinical team share the same work related goals as I do	3.71
	People in my clinical team understand the work I do	3.94
	People in my clinical team respect the work I do	4.07
Engagement with the organization = 3.08	I feel strongly connected to this health board	2.73
	I share the goals and values of this health board	3.23
	My employment with this health board is a big part of who I am	3.30

## Engagement with the job

The interviews, however, were more revealing in explaining how consultants' engagement with their jobs remained strong despite the demands placed on them by increased bureaucracy and managerialism, and the lack of resources to do their jobs. The following quotations illustrate high levels of work engagement despite the negative demands and resources issues raised by them:

*I'm as committed as ever to my patient care ... but I'm in every other way utterly frustrated I'm actually more often saying to patients that I have limited responsibilities in being able to care that they may be asking for (Surgeon).*

*I think I'm equally committed, perhaps more committed and your goals do change between being a junior and a consultant. I'm more committed to run a service, a successful, well-run service. Day-to-day when we are committed that's why we're here that's why we're doing the job if you're not committed then you're in the wrong place but on a day-to-day basis ...my commitment to perform the job within the organisation is challenged through a series of frustrations ..., just small things but it's small things happening recurrently which don't necessarily and they're not safety issues ... but we're not being supported in our day-to-day ... which makes then our working less efficient (Free text comment).*

*All these things mean I find my consultant role increasingly stressful despite being part-time... This is having a huge bearing on stress affecting my home life, enjoyment of work. I still love seeing patients and helping them with their conditions, but am finding the conditions I'm working in are becoming more and more difficult. Apologies for the rant, but all has to be said (Free text comment).*

*I am still a professional; I am still committed and reliable. When you start in the NHS you are a bit green, a bit naïve and think that the NHS is wonderful. Now I find it all a bit more tiring but I am just as committed. A bit more jaded and cynical perhaps but the buck stops with you and you have a responsibility, a moral responsibility to your patients (Surgeon).*

As noted earlier, one substantive cause of dissatisfaction and demotivation that was frequently aired was the implementation of the consultant contract initially negotiated in 2004. This was raised by many interviews but was raised most vociferously in the free text comments, some of which are set out below:

*I suppose it comes down to what do you mean by 'de-professionalised' as I am still a professional and I am committed to my profession and I think others would say the same. But there is a sense of disappointment and dissatisfaction*

*amongst many consultants and that's a consequence of the changes to their contracts, the wider changes in the NHS and the ever-growing demands and pressures on their time (Surgeon).*

*Financial constraints are always in evidence. Management is reduced to fire-fighting - long-term solutions are extremely rare. Scottish Government strategy of offering a poorer Consultant contract in Scotland compared to the rest of the UK over several years has been very short-sighted and is causing increasing problems in recruitment - especially outside the central belt (Free text comment).*

Most of the criticism was reserved for the implementation of a "9:1 contract" by management, which was seen by some as devising, intensifying work pressures and devaluing the discretionary effort of contract:

*The continuing recruitment to 9:1 DCC:SPA contract is harming the healthcare system - no time for service development work, poorer educational supervision. Even on a 7.5:2.5 contract the SPA work is often displaced by DCC activity and time at work delivered is almost 2 sessions more than remunerated with management reluctant to acknowledge the work. While this winter has been difficult due to increased demand on admissions, senior management is focused on discharge to "make room and avoid queues of ambulances at the front door" rather than looking for good clinical outcomes and appropriate discharge when ready. Many consultants are feeling outside of their comfort zone in what they are being asked to do. Social care and the failure of social work to provide rapid intervention in crisis care and to provide timely care packages and care home placement when necessary is having a very large impact on hospital services (Free text comment).*

*The 9:1 contract split was the most stupidly divisive policy. It has created bitterness and dissatisfaction in previously harmonious departments where people on 9:1 have to belittle themselves scrabbling around for the honour of perhaps getting another 0.5 SPA to do the many hours of work they are otherwise doing in their own time whereas more senior colleagues on 2.5 SPA are under no obligation to actually perform 10 hours of useful work for the Board (some do way more than this of course, but many barely lift a finger and are noticeably absent in fixed SPA sessions).... (Free text comment).*

*It would make such a difference if my colleagues and I received more support for our SPA activities. There has been little movement on the 9:1 split in my health board. This can be demoralising, de-motivating and make me feel that the extra work I do is not valued (Free text comment).*

*Managers have brought in 9:1 contracts, which indicates they have no respect for the huge amount of non-clinical work that we do, in Scotland they have got rid of merit awards and they are getting rid of discretionary points.*

*Therefore, all the extra work that we might do to develop a service, partake in research, develop teaching programmes or become involved in College groups to overall improve patient care is unrewarded. The health boards are creating a group of doctors who will do the bare minimum required of them as there is little incentive to work more in their spare time anymore. Also, the health service is driven and resourced around targets which are not necessarily the most important aspect of healthcare... (Free text comment).*

Although a minority view, there was evidence that the weight of demands placed on consultants by implementation of the contract and the lack of resources were sufficient to cause some doctors to consider leaving the NHS in Scotland prematurely or to emigrate:

*My workload and that of my colleagues is increasing exponentially. This is leading to increasing unpaid work for all of us. ...We are expected to deliver more undergraduate and postgraduate formal education without re-compensation. ... We are expected to see increasing numbers of patients without resource. When clinics have waiting lists we are expected to accommodate extra patients and overbook the clinic. The extra work we do is not valued or recognised by management. I am increasingly irritated by "mandatory" trust and educational training that we are expected to do. Quite a bit of this is irrelevant to my work. I am at the point of burning out and I am very likely to retire as early as possible (Free text comment).*

### **Engagement with each other**

The interviews reflected the survey data in suggesting moderate to high levels of engagement with each other, with many interviewees expressing positive feelings about their clinical teams. This was most noticeable among specialities that were dependent on other clinicians (e.g. physiotherapists) to treat patients:

*I very much enjoy my clinical job as a consultant in a very effective and close multi-disciplinary team (Free text comment)*

*We have a consultant body within the hospital where we all meet as a group once a month, so all the consultants can get into one room. Within Radiology we have got a very good collegiate atmosphere, the number one priority has always been the patient...not our professional self-esteem, not or our professional standing, not our financial remuneration (Radiologist).*

*I think some of the specialist nurses that are around are absolutely excellent and I think we should all be motivated to deliver quality clinical care. Having a nurse who is skilled work beside you can be a very constructive relationship. (Surgeon).*

*Fantastic colleagues, lovely nurses, enthusiastic trainees on the whole. However, there is a lack of engagement from non-clinical managers as far as I can make out...(Free text response).*

However, views on 'super nurses' varied according to the qualities and experience of such individuals:

*We now have 'super nurses' taking on more and more new, previously medical, roles. When they are good they are fantastic, but it is about getting the best people into these roles. It takes time to develop individuals with the relevant skills and experience and there doesn't seem to be any succession planning at an organisational level. So if you build a department around two of these 'super nurses' and then they retire or move on then you are stuck because you can't replace them with someone with who only has six months training. (Surgeon)*

There was also a perception among some consultants that the employment of higher grade nurses had not resulted in a diminution of consultants' workload and, in some cases, may have caused it to increase:

*We have got senior nurses in higher grades able to do some of that work that doctors are doing because we don't have enough doctors. At this point in time it has not actually panned out reducing the workload for consultants; in fact it has been found that possibly there is more investigations that the nurses start. For example a simple thing, a patient coming into psychiatric ward, they will wait for twenty-four hours before they make a decision whether the patient can go out for smoking or not - and I think that's not a clinical decision, that is a risk management/risk containment that can be done by senior nurses in the ward. You don't need a consultant to come and tell you if the patient can go for a smoke or not. (Psychiatrist).*

*Nurses are taking on more roles but all the extra work they do still often comes back to us. There is a real focus on getting more for less. (Surgeon).*

## **Engagement with the organization**

As the survey data showed, consultants expressed only moderate levels of engagement with their employers, reflecting the typically 'cosmopolitan' orientation to work of medical professionals to their profession rather than the 'local' orientation of non-clinical managers. It also reflects the negative attitudes towards bureaucracy and managerialism in their workplaces and a strong sense of grievance held by many doctors. The following



free text comment is the exception that proves the rule by being notable as one of only two in the survey that made a positive reference to their board as a place of employment:

*I greatly enjoy my job and feel lucky to work at our Health board (name of board)(Free text comment).*

The next two quotations illustrated a typical reaction to these grievances, while the third proposed that early career consultants had disengaged from the organization:

*I'm refusing to go to any meetings, at the moment, until my job plan is sorted out (Radiologist)*

*...The only appreciation or sense of self worth I get from this organization stems directly from patients who do appreciate the work I do – there is never any feedback from the 'organization' in terms of praise for a job well done. Only dire consequences when the smallest thing goes awry. Patient complaints render one 'guilty until proved innocent' and the workplace feels like hostile territory...(Free text comment).*

*My senior consultant colleagues are becoming less engaged with our ever-changing management team, whilst junior colleagues seem to be "keeping their heads down" and "playing by the rules". This is allowing non-clinical, management policies to unduly influence our day-to-day clinical practice (Free text comment).*

For some interviewees, the problems were attributed to the impersonal nature of control in their organizations, top down decision-making and the lack of visibility of (mainly non-clinical) managers:

*Although the nature of medicine is that the work is fundamentally very rewarding on a personal level, the system of where one fits in the gigantic behemoth that is the NHS is quite depersonalising. There seems to be a huge disconnect between clinical and managerial staff with no visibility of managers on day-to-day level. Decisions are top down, solely financially driven and autocratic. It took 3 years of campaigning on my part to get agreement for 2 extra sessions to cover an enormous clinical workload comparable to other areas with far more clinical resources for the same work. Extreme political correctness and rule-bound mentality has diluted the relationship between doctors and patients and engenders a feeling of near paranoia at times. ... (Free text comment).*

Senior consultants also alluded to how the service had changed over time and how changes had affected engagement with their organizations:

*The NHS has changed enormously ... I started with the NHS in 1990 and at that stage one very much felt that the doctors made the clinical work and had some respect, lot of cohesion and there was a great sense of family between doctors and nurses and other workers. There was a tremendous amount of after-hours effort put in where people felt part of a team and they sort of gave all their time gladly. And I would say all that has changed. ... I think it's a tremendous loss to the NHS. Because it came with so much more giving of oneself both clinically and academically but also in looking out for each other and looking after each other so that people felt they could work with difficult problems and scary things, death, injury, pain, suffering, emotional heartbreak... Now we are isolated and fearful, protective, watching our backs and watching for big brother. And we have lost that ability to support and therefore give to our patients... now we feel we work because we have to work. .... It makes it a job instead of a calling or a profession and I preferred it when I was calling it a profession (Surgeon).*

A typical response of senior consultants who claimed to be disengaged with their boards was to seek engagement with organizations outside of medicine:

*So if there seems to be no point in being involved [in extra activities] then you've probably become more interested in developing interests outside medicine. So instead of staying an evening running a journal club or running a management think tank or whatever you might like to do that's hospital based I would probably go to a writer's group. And I'm enjoying writing but I never envisaged myself being somebody who would be so interested in developing interests outside of medicine. And I think many doctors are feeling the same way but they're not engaging in trying to do more ... there's been a vast drop off in doctors participating in extra after hours...if you want to organise something the likelihood of you being able to draw your colleagues in with you has become less and less and less (Surgeon).*

## **Engagement with the NHS**

As the survey results showed in Table 6, there were very high levels of engagement with the NHS and its values. Typical free text comments included the following:

*Generally I feel I work in a good system that values its employees and cares well for its patients (Free text comment).*

*I consider myself privileged to be involved in a service which can significantly improve quality of life for patients and helps them achieve their full potential (Free text comment).*

A substantial minority of consultants also pointed to the benefits of working in Scotland as opposed to the more market driven system in England, which was sometimes more evident among consultants coming from outside of the UK – a point we take up further in the section on system effectiveness:

*Coming to Scotland as a consultant is like returning to the NHS as it was intended. I have been able to develop services and introduce better practice supported by the management team based on best clinical practice and not always producing a reduction in costs (Free text comment).*

*I think by and large we are lucky to be working in Scotland as opposed to consultant colleagues in England. I work in a supportive and progressive unit where I am able to keep patients at the heart of everything...(Free text comment).*

*NHS Scotland is probably one of the best healthcare systems in the world mainly because patient safety is priority and systems are developed to achieve high quality, patient-centred care. Although there is considerable weightage given to saving money and better utilisation of available resources which quite often means no further investment, the converse of fleecing patients with huge bills for their care is non-existent unlike in many countries where healthcare is a business...(Free text comment)*

*England is worse than Scotland in terms of non-clinical management interference, not communicating or listening. England also worse in terms of political interference and constantly changing bureaucracy/schemes etc. However, NHS Scotland is not ideal in these respects (Free text comment)*

*Better than England: less obsession with competition and the involvement with the private sector (Free text comment).*

*Very glad I work in NHS in Scotland and not in England (Free text comment).*

However, there were a small number of dissenting voices, which pointed to how negative experiences of working in the NHS among some consultants may influence recommendations to young doctors or to them leaving the system entirely:

*I would no longer recommend working in Scotland or the UK as a doctor and am seriously considering emigrating. I have given the NHS time to see how it's changing, but it is going downhill faster and faster. It only cares about numbers and targets, e.g. waiting lists. It is not interested in what doctors think. Managers have a difficult job and treat the politicians and civil servants not the patients (Free text comment).*

*A job working in New Zealand or Australia grows more appealing by the week  
(Free text comment).*

## IMPACT ON CONSULTANTS' VOICE

In our review of the literature we defined consultant voice in terms of: (1) whether employees were encouraged to 'speak up' or remain silent, (2) whether their voice was exercised in a socially- constructive manner to improve decision-making, or as a form of retributive justice exercised by consultants over managers and the organization, and (3) the extent to which consultants felt they enjoyed democratic rights in their organizations and felt able to exercise a degree of control or task autonomy in their work situations.

The results from the survey show lack of voice to be the most negative factors in consultants' experience of work. Firstly, our confirmatory factor analysis provided some support for our definition of voice: items drawn from relevant scales related to points (1) and (3) were strongly inter-correlated and appeared to explain the highest proportion of the variance of seven components of a factor that is strongly related to deprofessionalization. Secondly, the items we used to measure positive encouragement for voice and participation recorded the strongest levels of disagreement of all items in the survey.

Thus, as Table 7 shows, the mean scores for managers being good at seeking consultants' voice and responding to their views were 2.3 (with only 13.4% agreeing/strongly agreeing) and 2.26 (only 11.2% agreeing/ strongly agreeing) respectively, while the mean for the proportion of consultants agreeing that communications between consultants and managers were good was 2.45 (only 20% agreeing/strongly agreeing). The mean scores for consultants agreeing that they were regularly consulted over changes made in their places of work and that senior managers in their Boards were good at allowing consultants to influence decision-making was 2.35 (20.8% agreeing/strongly agreeing) and 2.66 (25.4% agreeing/strongly agreeing) respectively.

There was a degree of variation among demographic categories in how they responded to these items, with, for example, those with experience of medical management recording significantly stronger perceptions of better communications ( $P<0.01$ ) and medical consultants, those employed outside of larger boards and those with no experience of working outside of NHS Scotland recording significantly stronger perceptions of better communications at the 5% level.

**Table 7: Consultants' Voice and Communications**

Survey item	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Mean
In general, senior managers in this Board are good at seeking consultants' views on matters that affect patient care	24.7	35.1	26.8	12.7	0.7	2.3
In general senior managers in this Board are good at responding to consultants' views and suggestions	27.1	31.2	30.5	10.7	0.5	2.3
Communications between consultants and managers in this Board are good	20.8	35.4	23.9	17.6	2.4	2.5
I am regularly consulted about changes made in my place of work	26.2	35.9	17.2	18.1	2.7	2.4
In general, senior managers in this board are good at allowing consultants to influence final decisions on patient care	16.2	28.7	29.6	23.7	1.7	2.7

In relation to how voice was exercised, as noted earlier in our findings on proletarianization, 56% agreed/strongly agreed that since first becoming a consultant they were more willing to take collective action as a means of expressing voice, representing a mean level of agreement of 3.51, most marked among early and mid career consultants.

Our interview data and the free text responses to the survey provide key insights into why these survey results were so negative. The following free text comments and the quotation regarding the lack of influence on day-to-day matters summed up the feelings of many consultants:

*The day to day Patient focused work is excellent; the day to day managing (as Clinical Lead) is demoralising as no-one seems to listen or be able to resolve our requests/problems/issues - includes beds and medical and nursing staff shortages in various areas and services which impact on the way we try to deliver care. With the resources we have we do an excellent job and I am proud to lead a very respected and dynamic department but the lack of influence on*

*important day to day issues that adversely affect us is staggering (Free text response).*

*I sometimes wonder why I'm a doctor because I don't get to make any of the important decisions about here you know so you know I think probably because we're expensive and it might be cheaper to get someone else to do it, there's a feeling of well get them to do it and I think that has divested us of responsibility and professionalism sometimes and I don't think it's something we want you know I don't think doctors are sitting around saying you know I'd love it if someone just did that difficult bit of my job I think we want all the difficult bits of our jobs, we just want to be able to do it you know so you know it's a bit of a case in point, the one thing I can do is detain patients which no one else can do so you know [laughs] you know ( Psychiatrist)*

*I have felt disillusioned, disempowered and not listened to when trying (with colleagues) to raise concerns about patient and staff well-being. How disappointing to work for an organization that is supposed to care for folk who doesn't even listen, far less believe in folk at the front line (Free text comment).*

*I think its time to consider consultant views with more 'weighting' in planning services as we are the individuals most aware of trying to deliver effective healthcare with limited resources in complex multi-site/ multi-agency systems. I don't think many managers understand or are fully aware of (possibly ignore) patient and career behaviours when seeking healthcare. Non-clinical managers are often unwilling to listen to requests for adequate resources to ensure clinical governance remains robust. I hope our views can be seen as helpful and truly as a reflection on protecting healthcare and patient safety rather than 'whining' (Free text comment).*

*There is very little communication between the Health Board and consultants within my specialty. Some health board concerns are passed along via medical managers at times, however this seems to be done in a fairly ad hoc way. It would be helpful to have regular communication, and more of an understanding of current challenges which the Board are being tasked to respond to (Free text comment).*

Worryingly, the next quotation attributed near sinister motivations to managers' desire to suppress consultants' voice:

*I think there's a lot of times where consultants are actively excluded actually from meetings, meeting structures have been changed or are reported to be going to change which seem to say so that you will all not be there you know a representative or you know things happen to slim down the amount of participation you can have you know and I think sometimes there are again it might sound paranoid but you know I think there are meetings that are arranged at times at notice to exclude the participation of consultants you know (Psychiatrist).*

One typical response to a lack of opportunity to exercise voice was to withdraw, which is evidenced by the following quotation:

*Well I think again like a lot of people I think that leads to a vacillation between feeling on the one hand I must go to these things, I must make sure that the point of view is put across, that patient care is you know maintained and that our views are represented into a helpless feeling of actually why do all of that because it isn't making a difference and I think you end up with a real learned helplessness model I think you know there's only so many times you shock the dog for going back and the dog just sits down and says I don't know what to do you know and it's a metaphor that comes to me frequently you know you curl up in the middle of the cage and you say do you know what I don't know which way to go. Do I withdraw and not go to any of these things and protect myself? Do I try and go to these things and feel nothing happens or I get shocked? You know you end up kind of paralysed or running between the two positions because you know I think we all feel we do want to influence things, we all feel we do know about our services and what's working and what's not but you know and again I think that's something that came out in Mid Staffs isn't it, people saying do you know what I knew there were problems, I felt like I should do something but I felt so disengaged from the process that God help me, I gave up you know (Psychiatrist).*

## SYSTEM EFFECTIVENESS

We have sought to incorporate a qualitative method of assessing those outcomes of changes in the experience of work of hospital consultants in Scotland that would directly impact on patient care. The interview data and free text responses have raised three questions, which we have chosen to focus on:

1. Do consultants value the NHS system, especially NHS Scotland, as an effective system for delivering efficient and effective patient care in theory?
2. Is the system working well in practice?
3. How could it be improved?

With respect to consultants' evaluation of the NHS, we found that the large majority regarded the system in a very positive light, which was accompanied, as we have already noted in the section on engagement, by a high level of identification with the values of the NHS, most noticeable in the survey results. Although some consultants during the interviews pointed to other systems of healthcare as being superior, most of the interviews show that consultants regarded the NHS as among the most effective systems in the world. The following two quotes, one from an indigenous surgeon, the other from

an overseas psychiatrist illustrate the high regard that most interviewees felt about the potential of the system to deliver effective patient care.

*I think the NHS is one of the valuable institutions in the world and I think that looking after the NHS should be of the highest priority in Britain. Having worked in healthcare systems that are not so altruistic and are incredibly harsh, so to say to the patient, I'm sorry you don't have money to get the leg prosthesis or a heart operation - you'll have to go home now - it is a terrible thing. It's a terrible situation to be in and I would like to have more positive acknowledgement of how important the NHS is on every level. To the public, to the work force because once it's gone it's gone and I think the dis-empowering doctors is helping to lose it... I think there are so few people alive now that remember what it was like before the NHS that they've stopped realising just how precious the NHS is. And people who have worked in other countries appreciate that. But most members of the public haven't lived or worked in other countries so they think well this is just how it is. ... I don't know how that message gets across to the public but there are so many negative publicities about the NHS is failing and so few publicities about what a fantastic service the public gets. And what a great relief it is to live in a country where that need has structures in place to enact. (Surgeon).*

*I think the services are pretty much completely different there is nothing like the National Health Service existent in India; the one which comes closer to it the government provided primary healthcare services are pretty much in shambles so most of the people are dependent on private healthcare providers so and that is very different to how well the NHS is configured here and you have got as they say treatment free at the point of delivery which is not the case in India where you have to pay pretty hefty fees to see doctors, to see, to get the investigations done, to have hospital admission and things like that can, in India like a psychiatric illness can very well ruin you if you are in India if you don't have enough money to do that whereas in the NHS people have got much more safeguards to have a quality of life despite chronic and enduring illness (Psychiatrist).*

What is noticeable about these quotes is the comparative element in both; in other words, when compared to overseas systems, most consultants viewed the NHS in a very favourable light. This was particularly evident among doctors from the Indian sub-continent and those trained in parts of continental Europe where medical care is not free at the point of delivery. This excerpt from an interview with an overseas-trained consultant provides a good illustration of the benefits of comparison, high regard for the Scottish system and self-selection:



*Interviewer: Does that give you an advantage, in being able to compare and contrast your experiences of not just the NHS in England but also with your international experiences?*

*Consultant Surgeon: Yes, it does. And it is very interesting to move about through different systems. And especially the German and the British systems, which are very different. And that's why I wanted to come back to the British system, because I admire it, and that's why I've moved further from England, to Scotland. Because I think the ethos of the whole NHS is a very positive one, for any country. So (for example) South Africa is, sort of, hanging in the wind, with having a huge private sector, and a very under-funded, um, government sector. Seeing there, what can be done from Britain, and then seeing it not so good, as well. So it is very interesting, and it's been very entertaining.*

However, the survey data suggest that this comparative perspective is not quite so straightforward. We analysed the data according to whether respondents had experience of other healthcare systems with which to make a comparison between systems. Almost two-thirds of our sample had experience outside of NHS Scotland, but this experience was not an important source of variation on views for most items. There were, however, some notable exceptions. They tended to hold significantly less favourable views of medical managers and non-clinical managers, and significantly less favourable views of communications within clinical teams and communications within their Boards. We do not have the data to examine these differences, but the interviews suggest that one possible explanation may be the comparison of some consultants between the NHS in Scotland and their experience in the NHS in other parts of the UK. While a substantial minority saw the Scottish system in a more favourable light, as the previous quotation illustrates, others saw it as too centralist and politically controlled when compared to the more market-based system in England:

*I worked as a consultant in England before coming to Scotland and it's the same, it was the same stuff on a sort of larger scale, it wasn't just where I was, it was a lack of forward thinking, it was a short term approach from politicians about you know a full year cycle of re-election I mean it was bigger and longer and required more inputs and it resulted in questions which I felt being asked to do the impossible repeatedly if not the impossible enough to grind you down significantly for a long time ... because we were a smaller department in Scotland it was more apparent. (Surgeon)*

This last point begins to tap into consultants' explanations of how well the system was working in practice. On this issue, most of the commentary pointed to a system under quite severe strain – having to meet ever-increasing and more challenging demands with fewer resources and less control over resources. Thus, one surgeon explained his worries

regarding over demands outstripping resources and the consequences it might have for him:

*I thought I was going to be at risk of running into serious problems by covering too many patients and too many sites without adequate support and somebody would die and I'd end up being the subject of a civil suit or at least the hospital would and I'd be hung out to dry. I didn't feel I could rely on support when they'd made such cuts and such changes and weren't listening to what was being said and yet expected me to, I thought I'd be hung out to dry to be honest if something went wrong and I didn't feel that I'd get support either from colleagues or management (Surgeon).*

A psychiatrist pointed to a range of factors in his world that were combining into a perfect storm of increased expectations and inadequate resources, which had caused him to retire early:

*I think from my point of view there were so many things coming together I've sort of described it almost as a sort of toxic combination, the changes to the tax and pensions, the changes to the retirement age, the hassles of revalidation all the things that came in with the Mental Health Act, reduced support from junior doctors, the impact of what's happening in social work and the expectations and the management style ... greater risk of litigation, very inexperienced nursing staff, poorly qualified locums and lack of secretarial support so all those factors made me decide to retire (Psychiatrist).*

Complaints about a lack of resources reiterate our earlier findings on the lack of faith in the competence of management to make decisions on resourcing, which appear to have caused this psychiatrist to withdraw from his previous development orientation:

*I've been very frustrated and the core service that I work with has been under threat not for any strategic reasons, not for anything to do with what we do or the evidence on which we work but because people who know nothing about it have decision making authority over it ... I'll try and fight as hard as I can to stop the service that's there from being destroyed but I'm not as interested as I was in innovation and developing (Psychiatrist).*

The next two quotations highlight the pressures faced by two physicians, the first of whom points to a favoured explanation of the source of such pressure – the local and national media – while the second invokes a political logic in causing pressure in the NHS system:

*I think it should be patient-centred but not patient-led because that suggests the patients should make the decision, I think it should be done things that are in the best interest of the patients within the confines of what we can provide within the organisation by means of placement and staff I suppose. I think some things it's very easy to make the correct decision but more when there's conflicting issues to try and help make decisions sometimes it's a bit more difficult and that's financial pressure, space pressures I think pressures. ...I think the NHS is under pressure, I don't think the public as a whole really understands just how much pressure it's under and I think the upsetting thing as a clinician within the NHS is that the press likes to bash the NHS and they want and I know locally, I won't buy our local paper because all it does is say how awful we are but ultimately they forget all the good things we do and you know most people are within the NHS because we want to do a good job and they want to do a good service for patients. (Physician).*

*It is I realise that they have everything is financially based effective and the bottom line is largely financial, however my bottom line is patient care and it's trying to it's my duty or our duty to ensure that we can delivery both good patient care and we've always been mindful of the financial thing because the NHS is not a bottomless pit as a resource. Sometimes I think that the political target based motivation of a lot of our services has been, has gone away in the wrong direction. It is the resources that have been spent on a simple doctor/patient interaction that could have been used far better, not necessarily, for example, just simply increasing clinics on a specific day but putting the infrastructure to deal with more patients in a more effective manner..... You hear about these different pots of money, the recurring and non-recurring pots of money, and the streams seem so separate... (Physician)*

Finally, these following three quotations highlight a common view held by many interviewees, which was a sense of or frustration or, indeed, hopelessness over how to make the system more effective. Thus one physician bemoaned an inability of medical managers to deal with his problems, the second, a surgeon points to systemic failure, while the third, worth quoting at length, epitomises the frustration with his situation in a very graphic way:

*I work in a small unit where we should all be working together and I came from a background where the medical person was the lead because they understood all aspects of what was being done and here I have nurses who if they don't want to listen to what I say don't, technicians who will do whatever they want unless it suits them to listen to what we say and they are all directly and separately responsible to managers. I have secretaries who have told me to talk to their hand so I find that incredibly frustrating and I don't want to be a line manager of nursing uniforms and what to do with the sandwiches in the fridge but it is important for patient care and safety and that has now become an issue. I have recognized many cases where patients are not being treated appropriately and I don't know where to take it. I've raised it with my clinical director who's a lovely*

*chap but the last few have been awful but this one is very sensible, very just and nothing's been done, my concerns have not been addressed (Surgeon).*

*We see it in the hospital service and it's... every patient will tell you, they want to be seen by the same doctor and in fact, the same (specialty). It's suddenly happened in dentistry now where it's even more crucial that the same practitioner performs the same sequence of treatment because they've decided what the treatment plan is and if another (specialty) sees that patient, he may not agree with the... the treatment that was first promoted. Um, so we have this situation now where people have been seen by the wrong consultants in the wrong specialty because they can't actually be seen by the person they should have been seen to who may have known them well from previous situations. It's hopeless...(Surgeon)*

*As an "ageing" consultant (i.e. over 50), having made a conscious decision to not go into medical management despite having clinical leadership roles locally, nationally and internationally, I find myself recently being sidelined as irrelevant and "only interested in patient safety" by various specialist nurse/ midwifery managers in their 30s, with whom I have to interact to do my job effectively. The idea of listening to experience, or that we should learn from incidents rather than just record them, is beyond their understanding. They are under such pressure to tick boxes. In my own hospital, for more than a decade we have tried to make our emergency theatre system efficient, but we do not have urgent bookable lists because there would not be enough space for the elective theatres and hence, waiting lists would suffer. Somewhere along the line, someone (our medical advisers to government) needs to tell the politicians to stop lying to the public by pretending that we can provide an emergency service as well as reaching waiting list targets. Forget waiting times- concentrate on quality of care, emergency services, maternity services- and I mean the ones that bail out the home births and midwifery led units- fund the labour wards and hospital maternity wards properly before building more underused low risk units...I do not have the solution. All I can say is that at the moment, I am completely despairing for our NHS. I have dedicated my life to the NHS. I have never done private practice. I am a complete workaholic. At the present time, looking at where we are, I feel like an utter fool for wasting my life on trying to do my best for patients within such a difficult system. I see idiots at the top in medical management and in politics. I see doctors in management cow-towing to nurses in management- nurses who are so punitive to each other it beggars belief. Thank God we have decency and dedication amongst the vast majority of doctors, nurses and support staff on the front line. That is what will save the NHS, if our current political leaders and medical management do not drive us off a bridge somewhere in the meantime (Free text comment).*

It is this last point that we found most dispiriting. Few interviewees had a strong sense of being able to control their working lives or offer solutions about how the system might be fixed, the consequences for which were increased stress or, in some

cases, decisions to exit. The following quotation refers to a 'burnout' assessment undertaken by one senior consultant physician:

*Well, I mean, my coping... I did a stress test for a few years for appraisal, I've done a burnout score. I was officially burnt out but I started doing the burn out score in... eight or nine years ago now and every year...*

The next free text comment illustrates frequently cited job demands and the impact of the 2004 consultant contract referred to earlier on creating stress:

*I work in frontline medicine. Overcrowding in AMUs and A&E departments is creating enormous stress for all those who work there, and is turning off trainees from a career in acute medicine and emergency medicine. It is non sustainable. The 9:1 contract contributes massively to this stress, is leading to burnout, limits innovation and doesn't reflect the variable intensity of medical specialties. It needs to be scrapped, and frontline specialists should be paid a supplement to reward their work intensity and to attract trainees (Free text comment).*

There was also a feeling among some older consultants of a 'world we have lost' and a generalised lack of accountability among clinicians for improving the system.

*In the olden days I don't know how far back I need to go for this to be valid, but there were people in jobs who knew what they were doing and had the courage to make a decision, matrons, senior consultants, heads of unit, that kind of thing. They're more hierarchical days. We're now in a committee day and I think people get promoted up to levels beyond their competence and probably beyond their knowledge. They're maybe very good at, you know, doing the paperwork. They're maybe very good at producing the right kind of reports and understanding what the overall, kind of, framework is that we're working within but they're not very good at understanding clinical decisions. So, I think the logic of decision making now has all been, if you like, subordinated to covering yourself and stakeholder involvement so that it's someone else's, you know... someone else is sharing the burden of the decision with you, and I think that means that decisions aren't made. That's my feeling of the logic and I think that's why it's going wrong. We've got too many people and nobody willing to, you know, stand up and be accountable and say, "Okay, I've taken responsibility for this" (Radiologist).*

To try to understand how consultants saw the system being improved, we asked them about two favoured solutions – getting more doctors into management and improving the quality of dialogue between consultants and managers. With respect to the first solution, as we noted earlier in the section on new medical elites, consultants wanted to see more doctors taking up medical positions but were concerned with that this did not result in the system being improved, at least

according to their professional logics. As we noted in the section on new medical elites, many consultants raised concerns over the suitability of some doctors for medical leadership positions. Such views were also held by consultants who are currently in a clinical leadership role, especially over the part time nature of the job and the internal conflicts they face in making a difference:

*My experience (of clinical leadership) ... personally, I find it a distraction. I found it very hard to do the... what I would call the day job as well as I would like because of all the harassment of trying to do the other things, um, and... and that's too conflicting, I think, for me. I think, you're either dumping work on your colleagues who are also busy or you're not doing the work properly and potentially, you're not doing anything properly, and that's... that's not good (Physician, clinical lead).*

*I have found the experience working as a leader in my specialty at NHS (name of board) most challenging. I have effectively done everything I can to act on the values inherent at all levels of society in accordance with the zeitgeist, the GMC, Social Policy, NHS and Health Board Policy in relation to good patient care and redesign of services with the utmost integrity. Key areas include service user and carer involvement in redesign and service delivery, values led approach to service delivery, shifting the balance of care and integrated working, In turn, senior management at Board level having paid lip service to these values during a redesign of services with wide representation at my insistence have 'betrayed' ( to paraphrase a third sector partner because I would not have felt comfortable using this term for fear of disciplinary action) stakeholders. At Director level, it was conceded that the hidden agenda - a large cut in budget despite public reassurances was done in a dishonest and uncollaborative (sic) way, an the size of the cut was unrealistic. Nevertheless the budget cut continued. So despite recording publicly a set of strategic values and aspirations, which I followed to the letter and acted on, efficiency savings and 'flow' (pushing people through the acute system as fast as possible) appear to represent the main senior management priorities at all levels (Free text comment)*

With respect to improving communications and dialogue, we have previously referred to the potential to bring about system change as best achieved by 'improving the quality of disagreements' as a first step in creating genuine dialogue between managers and doctors (McIntosh et al, 2012). This view was partly reflected in how most consultants wished to have greater voice in decision making and understanding of managers' worlds as a way of reducing distance and 'disconnects' between them. Some even cited examples of how improvement in genuine dialogue rather than competing monologues with managers and doctors talking to each other in a common language. However, the majority perspective was that their voice was not being heard, and that there was no dialogue, especially in

fundamental areas such as service delivery and the architecture of wards, departmental and hospital, redesign.

*Just listening to each other, I think, and having a genuine discourse. At times, you just sit in meetings and talk about the same things and nothing changes...you lose the will to live ultimately, there's a sense of futility...Because I think it's because the people having the dialogue with are not the right people. There are too many levels of staff...'*

*This disengagement, this disempowerment I've mentioned before is something that has been felt through that. We are trying desperately hard to increase the effectiveness of that and get consultants engaged but there are lots reasons why they're not engaged. It is because of that I've been involved in more discussions with managers who are supposedly looking at our interests and actually there's a lack of a desire to know where the things are going wrong. I think it's a case of if they don't know something's going wrong then they can't defend themselves (Physician).*

## DISCUSSION

In this section of the report, we summarise our key findings and attempt to explain their meaning with reference to the literature in our introduction and the theoretical framing of the research.

We set out to investigate consultants' changing experience of work since their first appointment, and chose to focus on a number of important outcomes: (1) their *engagement* with their jobs, with each other in clinical teams, with their employing organization, and with the values of the NHS, (2) their degree of *trust* in the organization and its management, in terms of competence, benevolence and honesty, (3) their opportunities to exercise *voice* and participate in decision-making, and (4) how these factors combine to shape their accounts of *effectiveness of the healthcare system* in Scotland. These were, if you like, our dependent variables, so what might explain them? The literature review pointed to the underlying belief systems of consultants concerning decision-making, organization and methods of evaluation, which are widely defined as *institutional logics* (Thornton et al, 2012) or rationales governing decision making and organizational culture. The medical professional literature focuses on the clash between a traditional medical professional logic shaping the worldview of most doctors with the business-financial logic (Reay & Hinings, 2009), most notably associated with New Public Management and performance targets (Ham, 2014). Our belief was that these logics underpinned well-documented but contested trends in the experience of medical professional work – *deprofessionalization*, *re-stratification* and *proletarianization*. To the extent that consultants in our study interpreted their changing experience of work in these terms, we would have expected to find a negative impact on most of the outcomes, i.e. engagement, voice, trust, accounts of system effectiveness and the potential to reform the system to reflect their definitions of its failings.

Inevitably, however, this study has some important limitations, especially concerning statistical generalization from the survey, which we have also acknowledged in our methods sections. However, the high degree of triangulation (or cross verification) arising from our mixed-methods approach to data collection gives us greater confidence in our findings and conclusions than had we used only one method of data collection. Our interviews provided key in-depth insights into the generally-held experiences of consultants described in the survey and into the variation and nuances in their accounts of the changing work experiences.

So, to our key findings:

1. We found some support for certain elements of the broad deprofessionalization thesis and the related notions of re-stratification and proletarianization among our interviewees and survey respondents:
  - a. Consultants saw increased patient demands as challenging and in some cases misplaced. They attributed such views to the role of politicians, the media and enhanced access to self-diagnosis through the Internet in



creating a 'want it now' culture in a system that was increasingly resource-constrained. Such expectations, however, have been unequally distributed among the Scottish population. In under-privileged sections of Scottish society, many patients and their families were still unlikely to challenge medical opinion or practice, which was not the case with the affluent middle-class, who often placed greater demands on consultants.

- b. Nevertheless such challenges had not caused consultants to feel that their status with patients had been diminished; indeed the general feeling was that patients continued show them high levels of respect, and trust in their judgement and integrity, despite the constant media attention on failings in the healthcare system. Moreover, many consultants welcomed more informed patients and an appropriate degree of challenge to the, somewhat anachronistic, notion of omnipotent doctors.
- c. Internally, however, the picture was very different; many of our interviewees felt devalued not by their patients but by management and bureaucratic controls. The levels of negative comment and graphic accounts of how increasing bureaucracy and non-clinical managerialism had shaped changes in their work experience were among the most marked features of the research. These feelings were especially strong in relation to the dysfunctional consequences associated with (a) the introduction and implementation of waiting times and targets, (b) the nature and implementation of the consultants contract (b) multiple layers of needless paperwork, and (c) the impact of non-clinical managers in exercising, often distant (in terms of geography and values), control over their working lives (MacIntosh et al, 2012; Martin et al, 2015).
- d. Consultants tended to see the increasing power of non-clinical managers as especially invasive and inconsistent with improving patient care. Although they had sympathy for non-clinical managers' position of being between the 'rock' of political control from governments and the 'hard place' of lack of respect for their competence among many consultants, this did not translate into feeling that they were all working together to achieve common goals. Many consultants spoke of the imbalance of power having gone too far in the direction of detached managerialism, and the need to redress this balance. There was, however, some variation among the different demographic groups in how they viewed both increasing bureaucracy and managerialism. Younger consultants and, particularly, consultants with experience of medical management tended to have less negative views, a finding that was fairly consistent with other studies (MacIntosh et al, 2012)
- e. Increased self-regulation introduced by elite medical bodies such as the GMC was seen in a no more favourable light than controls imposed externally by politicians, civil servants and non-clinical managers. Attempts to introduce processes such as revalidation and appraisal were

not interpreted by consultants as particularly positive initiatives in improving system effectiveness or in improving the development of early and mid-career consultants. Though appraisal was typically described as “good in theory”, the practice of “box-ticking” had resulted in the system lacking validity among appraisers and appraisees, and as a ‘waste of time and money’. The issue of selection of appraiser was raised, with questions often being asked of appraisers whose judgements were seen to be governed by a business-related logic rather than a medical professional logic.

- f. The introduction of clinical leadership and medical managers drew mixed views. On the one hand, most consultants wished to see more consultants in such roles, but the experience of appointing consultants to these positions has not led to major improvements in the system nor to perceptions that medical judgements were being furthered in decisions taken at senior levels of Board management. Indeed, in line with much of the literature on clinical leadership in practice, consultants without such experience tended to see colleagues who had taken up medical management positions as having become incorporated into a different logic of governance (Currie et al, 2015; Martin et al, 2015). As might be expected, we found that those consultants with experience of medical management and clinical leadership tended to see things differently, although they recognised the part-time nature of many clinical leadership roles was a problem in creating the kinds of changes desired by many consultants, and sometimes caused those who followed such a route to experience high levels of stress arising from role conflict.
- g. There was mixed support for the proletarianization thesis. Firstly, consultants rejected the idea of deskilling and lack of job challenge, with many reporting greater job challenge as their careers progressed. However, routinization of medical judgements was evident, with new bureaucratic procedures and the control exercised by non-clinical management causing them to “fall in line”. There was also evidence among some interviewees and in the free text comments suggesting that consultants had experienced an attack on their traditional status as the most highly-valued and highly-qualified professionals in the healthcare system; instead they were increasingly subject to a wage-work bargain like any other member of the ‘workforce’. Such feelings were also evidenced by comments concerning the introduction of unnecessary dress codes, the decreased quality of office accommodation, and the lack of meeting spaces for consultants, which were sometimes seen as a symbolic challenge to their status, and as dysfunctional to effective working and to the traditional communities of practice that had existed among consultants in previous eras. One consequence of these feelings of proletarianization was the increased willingness of consultants to take collective action, which was more evident among earlier career consultants.

2. There was widespread agreement that business-related rationale dominated decision making, which was seen to be often incompatible with the traditional logic of medical professionalism, which consultants tended to equate with good patient care (Reay & Hinings, 2009). While the NHS has always had to accommodate potentially conflicting rationales, consultants felt that the balance had 'tipped too far' towards business and financial decisions governing how work was organized and evaluated, and this trend was inconsistent with effective, and indeed, efficient patient care. No less important, however, many consultants perceived the business-related logic to be linked to (and often caused by) political commitments made to an ageing and more informed general public without providing the necessary levels of finance to match these pledges. Thus constant and unsustainable drives for efficiency and reforms of the healthcare system had become an endemic feature of the system from which there was little escape unless the situation was tackled at a macro political level.
3. One of the strongest findings related to lack of opportunity for consultants to express their voice, and to the lack of impact of their voice in decision-making over issues that directly affected their working lives and, to a lesser extent, patient care. The results from the survey show these aspects of the decreasing opportunities to express their views to be the most negative aspects of consultants' experience of work. There was, however, some variation among demographic categories in how they responded to the survey. Thus, consultants with experience of medical management and earlier career consultants recorded significantly better perceptions of communications. The interview data indicated that some consultants saw this lack of opportunity to their views as a deliberate strategy taken by non-clinical managers to disempower consultants, or to avoid confrontation over difficult decisions.
4. There was strong evidence of a lack of trust in managers in general and trust in the senior management of boards. Consultants responded to bureaucratic control and managerialism by expressing a marked lack of trust in the competence and integrity of non-clinical managers and, to a lesser extent, medical managers. Not surprisingly, consultants with experience of medical management were more inclined to trust the system, and to have a more positive view of doctors becoming involved in clinical leadership and medical management as a solution to improving the system through consultation and communication.
5. Given the feelings of deprofessionalization among many consultants and lack of trust and voice, the data on engagement - somewhat surprisingly - showed that consultants remained highly engaged with their jobs, with their clinical colleagues and the values of the NHS. Engagement with the values of the NHS in general was particularly high, with some consultants pointing to the virtues of the NHS in Scotland as a major influence on their engagement. However, as predicted, engagement with their Board employer was only moderate, which reflects the cosmopolitan rather than local orientation of medical professionals, the negative

attitudes towards bureaucracy and managerialism, and a strong sense of grievance among many consultants over a lack of voice.

6. Regarding system effectiveness as an outcome of deprofessionalization of consultants, the majority of consultants described the NHS in a very positive light, and identified strongly with the values of the NHS, most evident in the survey data. Although some consultants pointed to other systems of healthcare as being superior in some ways during the interviews and in free text comments, the weight of data showed that consultants regarded the NHS as among the most effective systems in the world - but one that was suffering under the strain of having to do progressively 'more with less' under current funding regimes. Pressure to do so came from politicians over-promising to deliver 'world-class' healthcare, sometimes exacerbated by local and national media seeking 'bad news' stories, without providing the necessary levels of year on year funding that kept pace with the 'demand inflation' generated by politicians, the media and the public. Among interviewees, a widely shared response to these pressures was a sense of or frustration, sometimes bordering on hopelessness, over how to make the system more effective. In some respects, we found this last point the most dispiriting – that few interviewees had a strong sense of being able to control their working lives or offer solutions about how the system might be fixed, the consequences for which were increased stress or, in some cases, decisions to exit. While consultants wanted to see more doctors in management, many fewer had faith that consultants in management roles were capable of changing institutions outside of their control (Currie et al, 2012). Instead, most consultants pinned their faith on improving the opportunities for consultant voice, though without much faith that greater voice and participation in decision-making would or could change the now established political and economic institutions of healthcare in the NHS.

These findings, as we have argued, are consistent with certain aspects of the literature on medical professionalism and deprofessionalization. They suggest that much of the managerial faith placed in medical/clinical leadership as a means of creating institutional change in the NHS in the UK may be over-optimistic (Currie et al, 2012; Martin et al, 2015). Instead, we argue that newer literature on institutional change in health care, combined with aspects of deprofessionalization, provide a better explanation for many of the views expressed to us by consultants, and for the survey results. Our data suggest that many consultants see a business-related logic and a political logic as the dominant rationales governing the NHS, with medical professionalism as a proxy for patient care becoming increasingly peripheral.

However, as we have also seen the picture is complicated by different groups of consultants interpreting business-related and political logics in different ways, depending on the stage in their career, their specialty and whether they had experience in medical management. Thus, although we might be able to talk usefully about a medical professional rationale, we found evidence of distinctive sub-cultures in our data, which shaped how these different groups, with sometimes, distinctive identities and frames of reference, interpreted changes in their work experience. As Besharov and Smith (2014)

have argued, an organization can be segmented according to how different groups see the compatibility of multiple logics in their organization. Our data suggest that those consultants with previous or current experience of medical management were able to align the competing business-related, political and medical professional rationales more easily than the majority of consultants without such experience. This reconciliation was also partly, but not wholly, evident among early career consultants, who had been socialized into a managerialist NHS during earlier training, and among certain specialties (though the reasons for this were not clear). Such an analysis suggests to us that improving respectful dialogue between managers and consultants as a first step may help the system function more effectively on the ground. However, we are less sure that improved voice and communications will deal with the feelings of deprofessionalization evident in this study.

## CONCLUSIONS

We sought to understand changes in consultants' work experience over the course of their careers. We set out to investigate consultants' changing experience of work since their first appointment, and chose to focus on a number of important outcomes: (1) their *engagement* with their jobs, with each other in clinical teams, with their employing organization, and with the values of the NHS, (2) their degree of *trust* in the organization and its management, in terms of competence, benevolence and honesty, (3) their opportunities to exercise *voice* and participate in decision-making, and (4) how these factors combine to shape their accounts of *effectiveness of the healthcare system* in Scotland. Our starting point for the study was the literature on the sociology of the professions, organization and management research, and especially the deprofessionalization of medical careers, the last of which is widely discussed in medical and social science journals.

To answer our research question on the impact of changes in consultants' experience of work, we undertook an extensive interview and survey programme. Our main conclusions are that deprofessionalization, lack of trust in managers and a lack of voice and genuine participation in decision making are widespread and, if not acted on, may have significant consequences for system effectiveness. However, these perceptions and accounts of deprofessionalization were not matched by doctors' disengagement from their work, from each other in clinical teams, or from the values and aims of the NHS in Scotland. Indeed, engagement levels among most consultants remained high, a conclusion from which all stakeholders in the NHS in Scotland can take some comfort. However, one might reasonably infer from these conclusions that a healthcare system in Scotland is under significant strain and is currently being held together, in part at least, by consultants' innate sense of obligations to patients and intrinsic rewards from their jobs, despite experiencing considerable dissatisfaction with many extrinsic factors in their working environment. The most significant of these 'dissatisfiers' are their perceptions of loss of autonomy through an increased emphasis on the increasing financial, bureaucratic and democratic logics governing decision-making in the NHS in Scotland, and, to a lesser degree, increased internal regulation by elite medical bodies and medical managers.

The general picture we have gained from our research is the large majority of consultants in our study have significant concerns over the impact of the new managerialism, bureaucratic, financial and political controls on their medical professionalism and evaluations of the sustainability of the healthcare system. They see themselves as holding one of the best healthcare systems in the world together in the face of cumulative challenges from increased expectations, media scrutiny, and demands resulting from demographics and technological advances, which are decreasingly met by proportionate rises in financial resources from governments. As researchers, we could not be other than impressed with the levels of engagement that interviewees expressed about their jobs and colleagues. At the same time, however, we detected a strong note of pessimism over how the healthcare system could be improved for the benefit of all stakeholders. This

is rather negative note on which to end but one that requires 'urgent treatment'. In some earlier research (Martin et al, 2015), we referred to the mutual isolation that characterizes doctor-manager relationships, which only serves to increase the psychological distance between them by defining 'who they are' by 'who they are not'. Such isolation decreases the potential for sharing values, expectations and better methods of working. So, perhaps findings ways at local level to generate respectful dialogue (rather than competing monologues) between consultants and managers might be a good first step, if only to improve what we have previously described as the 'quality of disagreements' between them.

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## Appendix 1: Interview Guide for Participants

1. Can you give me some background on your career since leaving medical school, especially your career as a consultant? If you've had experience in different Boards or healthcare systems, how would you compare them?
2. There are a number of changes in the NHS over the years that may have affected your experience of work. I would like to ask you about some of them to see how they accord with your experience

- What about the changing expectations of patients and attitudes of the general public towards doctors and the healthcare system. Have patients' expectations and attitudes changed during your career? If so, how has this affected you?

What about increasing bureaucracy, routinization of work and the changing role of managers. Have these been an important feature in your experience of work during your career?. If so, could you tell me how?

- What about the role played by medical bodies in exercising control over the profession. Has this been a feature that has impacted on the profession and your work? If so, how?
3. Do you feel your ability to influence key decisions has increased or decreased over the time you have been a consultant? What about the balance of power between consultants and managers? How do you feel about that? To what extent has it affected ability to do your job well? To what extent do you trust managers here to act in your best interests?
  4. Do you feel more committed or less committed to your work now than when you began? Why is that?
    - What about your engagement with matters outside of your immediate work. Has that changed over time?
    - Have incentives or the lack of them played any role in your engagement?
  5. Do you sense increased tensions between medical consultants and other clinical professions since you began as a consultant? Or are things pretty much as they've always been?

6. Has there been any blurring of the professional boundaries between consultants, nurses and other clinical professions, during your career? If so, how do you feel about this? And has it affected your ability to do your job?
7. How do you suggest the situation can be improved to allow consultants to do their job more effectively and give you a better experience of work?
  - What about getting more consultants into clinical leadership roles and/or into the overall management structure in this Board?
  - What about other ways of improving the work experience and effectiveness of consultants?
  - What do you currently do to cope?
8. Which rationales do you think govern decisions made in your work?
9. Which rationales should dominate decision making?
10. Is there anything you would like to tell us that we would find useful for our research?

## **Appendix 2 Questionnaire**

### **INTRODUCTION**

We are academics from the Universities of Dundee and Glasgow conducting research into the changing work experience of hospital consultants in the NHS in Scotland in cooperation with the BMA Consultants' Committee. So we would be very grateful if you could take about 10-15 minutes to complete the following questionnaire.

We think you will find the questionnaire relevant and interesting since most of the questions are derived from the first stage of our research, which involved seventy plus in-depth interviews with consultants in a range of specialties, age groups and locations throughout Scotland. Other questions have been developed from standard scales on issues such as trust, communications and engagement.

To help us gain as complete a picture as possible, your views are essential; thus we hope you can put aside the necessary time to complete the whole questionnaire. Please rest assured that this research project has gained full ethical approval from the University of Dundee ethics committee. The survey is completely anonymous, and individual responses will be kept confidential at all times. Only the research teams from Dundee and Glasgow Universities will have access to the data and only collated statistics will be used in the final report for the BMA and any subsequent academic articles or conference papers.

The questionnaire is in two sections. The first one asks you to check the point on a 5 point scale (1 = strongly disagree to 5 = strongly agree) that most closely reflects your views on a range of statements. The second section asks you for some details about yourself, your job and where you work, etc., to help us analyse the data more effectively.

We do ask you complete all questions so that we can gain as complete a picture as possible; so if you need to it is possible to save your responses at any stage and return to the questionnaire to finish it.

QUESTION SET 1/8

1. Patient expectations nowadays often outstrip the resources available to me to deliver effective patient care
2. Patients generally show respect for my role as a consultant in their dealings with me
3. Patients generally have trust in my judgements and ability to treat them effectively
4. I have one eye on potential complaints when treating patients
5. My work has become less challenging since I first became a consultant
6. I constantly seek fresh challenges in my work
7. My job has become increasingly governed by bureaucracy (e.g. target setting, form filling, etc.) since I first became a consultant
8. I see the bureaucracy as an essential, if not always welcome, element of my job
9. Most of the bureaucracy is unnecessary and gets in the way of delivering effective patient care
10. Since first becoming a consultant, non-clinical managers seem to have taken a bigger role in decisions that affect my working life

QUESTION SET 2/8

11. The increasing influence of a managerial agenda in my organisation has made it very difficult to do my job effectively
12. Generally speaking, non-clinical managers in this Board have too much influence over service delivery in my hospital
13. Generally speaking, non-clinical managers in this Board are trying to do a difficult job in difficult circumstances
14. Generally speaking, non-clinical managers have a sufficiently good understanding of my work to exercise their responsibilities effectively
15. Communications between consultants and managers in this Board are effective
16. I am regularly consulted about changes made in my place of work that directly affect me

17. I have respect for most non-clinical managers in this Board and the work they do
18. Medical managers in this Board tend to do an effective job of managing service delivery
19. Medical managers in this Board tend to do an effective job in representing the interests of consultants to senior management
20. I have respect for most medical managers in this Board

QUESTION SET 3/8

21. Whenever clinicians take up a medical management position they seem to become a different person
22. Clinicians who go into medical management positions are frequently seen to have 'crossed a line in the sand' in this Board
23. We need more clinicians in senior leadership positions in this Board
24. The GMC has generally been effective in exercising self-regulation of consultants
25. Since first becoming a consultant, I have become more willing to take collective action to gain a voice in matters that affect me
26. The GMC has introduced unnecessary levels of bureaucracy to self-regulating the profession
27. The appraisal process for consultants is effective as a development tool
28. The appraisal process works well for the purposes of revalidation
29. Revalidation is a necessary process to protect the public
30. I feel that most non-clinical managers in this Board would act in my best interests

QUESTION SET 4/8

31. Most non-clinical managers in this Board do a competent job
32. I would characterise most of the managers in the Board as honest in their dealings with consultants
33. Generally speaking, business and finance-related judgements govern most decisions in this Board



- 34. Generally speaking, medical judgements concerning what is right for patients govern most decisions in the Board
- 35. There is an appropriate balance between medical judgement and business and financial needs in most decisions in this Board
- 36. I find the work that I do full of meaning and purpose
- 37. At my work I always persevere, even when things don't do well
- 38. I feel happy when I am absorbed in my work
- 39. People in my clinical team communicate frequently about important work related issues
- 40. People in my clinical team communicate accurately about important work related issues

QUESTION SET 5/8

- 41. People in my clinical team share the same work related goals as me
- 42. People in my clinical team understand the work I do
- 43. People in my clinical team respect the work I do
- 44. Being a consultant plays a big part in my sense of who I am
- 45. My employment in this health board is a big part in my sense of who I am
- 46. I share the goals and values of this health board
- 47. I feel strongly connected to this health board
- 48. I share the goals and values of the NHS
- 49. In general, senior managers in this Board are good at seeking consultants' views on decisions that affect patient care
- 50. In general, senior managers in this Board are good at responding to the views and suggestions from consultants

QUESTION SET 6/8

51. In general, senior managers in this Board are good at allowing consultants to influence final decisions on patient care

52. I feel my role as a consultant has been diminished by unnecessary dress codes

53. My ability to do my job effectively has been made more difficult because of my office accommodation

#### QUESTION SET 7/8

Could you provide us with some basic details about yourself so that we are able to analyse variations in the responses to the above questions. Please be assured that no single person can or will be identified from the answers you give us in our written report.

54. How many years of experience do you have as a consultant?

- 1-4 years
- 5-9 years
- 10 year or more

55. Are you currently employed in a:

- Full-time post
- Part-time post

56. What is your speciality:

- Investigative (Radiology and Labs, etc)
- Women and child health care
- Anaesthesia
- Surgery
- Psychiatry
- Medicine
- Other

57. Is the Board you are employed by:

- A large urban board (Greater Glasgow & Clyde, Lothian, Tayside and Grampian)
- A medium-sized board (Ayrshire & Arran, Borders, Dumfries & Galloway, Fife, Forth Valley, Highlands, Lanarkshire)
- A remote/small/island board (Orkney, Shetlands, Western Isles)
- A non-territorial board (e.g. NHS Education for Scotland)

58. Is your normal place of work in:

- A large University teaching hospital
- A medium sized urban hospital
- A rural hospital
- A single or limited speciality hospital
- Other

#### QUESTION SET 8/8

59. Do you consider yourself, or have you been, a medical manager?

- Yes
- No

60. Have you had previous experience of working in other health boards as a doctor?

- Yes
- No

61. Have you had previous experience or working as a doctor in other healthcare systems outside of NHS Scotland?

- Yes
- No

62. Is there anything you would like to tell us about your experience of working as a consultant in Scotland that you would like to elaborate on in the free text box below

### Appendix 3: Survey Breakdown of Demographic Groups

#### Years of experience as a consultant

Answer choices	% of total responses
1-4 years	18.43
5-9 years	21.01
10 years of more	60.56

#### Type of employment contract

Answer choices	% of total responses
Full-time post	86.82
Part-time post	13.18

#### Specialty (n=1009)

Answer choices	% of total responses
Investigative (radiology, labs etc.)	11.79
Women and child health care	9.91
Anaesthesia	15.56
Surgery	16.75
Psychiatry	11.60
Medicine	21.01
Other	13.38

### Type of Board

Answer choices	% of total responses
Large urban board (Greater Glasgow & Clyde, Lothian, Tayside and Grampian)	62.83
Medium-sized board (Ayshire & Arran, Borders, Dumfries & Galloway, Fife, Forth Valley, Highlands, Lanarkshire)	35.58
Remote/small/island board (Orkney, Shetlands, Western Isles)	0.50
Non-territorial board (e.g. NES)	1.09

### Normal place of work

Answer choices	% of total responses
Large university teaching hospital	42.91
Medium-sized urban hospital	37.66
Rural hospital	6.84
Single or limited specialty hospital	5.25
Other	7.33

### Do you consider yourself, or have you been, a medical manager?

Answer choices	% of total responses
Yes	28.06
No	71.94

**Have you had previous experience of working in other health boards as a doctor?**

<b>Answer choices</b>	<b>% of total responses</b>
Yes	88.26
No	11.74

Have you had previous experience of working as a doctor in other healthcare systems outside of NHS Scotland?

<b>Answer choices</b>	<b>% of total responses</b>
Yes	64.28
No	35.72